

# ARKANSAS CODE OF 1987 ANNOTATED



## 2013 SUPPLEMENT VOLUME 20B

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(CHAPTERS 1-44 IN VOLUME 20A)

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tions against threatened patient violence — Duty to warn.

**20-45-201. Definitions.**

As used in this subchapter:

(1) “Licensed certified social worker” means a licensed certified social worker licensed by the Arkansas Social Work Licensing Board under § 17-103-306(c) who provides mental health services;

(2) “Licensed marriage and family therapist” means a licensed marriage and family therapist licensed by the Arkansas Board of Examiners in Counseling under § 17-27-303 or § 17-27-304 who provides mental health services;

(3) “Licensed professional counselor” means a licensed professional counselor licensed by the Arkansas Board of Examiners in Counseling under § 17-27-301 who provides mental health services;

(4) “Mental health services provider” means a licensed certified social worker, licensed marriage and family therapist, licensed professional counselor, physician, psychologist, or registered nurse who provides mental health services;

(5) “Patient” means an individual with whom a mental health services provider has established a patient-care provider relationship;

(6) “Physician” means a physician licensed by the Arkansas State Medical Board who provides mental health services;

(7) “Psychologist” means a psychologist licensed by the Arkansas Psychology Board who provides mental health services; and

(8)(A) “Registered nurse” means a registered nurse licensed by the Arkansas State Board of Nursing who provides mental health services.

(B) “Registered nurse” includes an advanced practice nurse.

**History.** Acts 2013, No. 1212, § 1.

**20-45-202. Duty of mental health services provider to take precautions against threatened patient violence — Duty to warn.**

(a) A mental health services provider, hospital, facility, community mental health center, or clinic is not subject to liability, suit, or a claim under § 19-10-204 on grounds that a mental health services provider did not prevent harm to an individual or to property caused by a patient if:

(1) The patient communicates to the mental health services provider an explicit and imminent threat to kill or seriously injure a clearly or reasonably identifiable potential victim or to commit a specific violent act or to destroy property under circumstances that could easily lead to



serious personal injury or death and the patient has an apparent intent and ability to carry out the threat; and

(2) The mental health services provider takes the precautions specified in subsection (b) of this section in an attempt to prevent the threatened harm.

(b) A duty owed by a mental health services provider to take reasonable precautions to prevent harm threatened by a patient is discharged, as a matter of law, if the mental health services provider in a timely manner:

(1) Notifies:

(A) A law enforcement agency in the county in which the potential victim resides;

(B) A law enforcement agency in the county in which the patient resides; or

(C) The Department of Arkansas State Police; or

(2) Arranges for the patient's immediate voluntary or involuntary hospitalization.

(c)(1) If a patient who is under eighteen (18) years of age threatens to commit suicide or serious or life-threatening bodily harm upon himself or herself, the mental health services provider shall make a reasonable effort to communicate the threat to the patient's custodial parent.

(2) If the mental health services provider is unable to contact the patient's custodial parent within a reasonable time, the mental health services provider shall make a reasonable effort to communicate the threat to the patient's noncustodial parent or legal guardian.

(d) A mental health services provider, hospital, facility, community mental health center, or clinic is not subject to liability, suit, or claim under § 19-10-204 for disclosing a confidential communication made by or relating to a patient if the patient has explicitly threatened to cause serious harm to an individual or to property under circumstances that could easily lead to serious personal injury or death or if the provider has a reasonable belief that the patient poses a credible threat of serious harm to an individual or to property.

(e)(1) If a patient in the custody of a hospital, community mental health center, or other facility threatens to harm an individual or property, the mental health services provider and the staff of the hospital, community mental health center, or other facility shall consider and evaluate the threat before discharging the patient.

(2) Under subdivision (e)(1) of this section, the mental health services provider may inform an appropriate law enforcement agency and the victim of the threat.

(f) Subsections (a) and (c) of this section apply to a hospital or facility that has custody of a patient who has made or makes a threat to harm an individual or property.

**History.** Acts 2013, No. 1212, § 1.

CHAPTER 46  
MENTAL HEALTH AGENCIES AND FACILITIES

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SUBCHAPTER 1 — GENERAL PROVISIONS

SECTION.

20-46-105. Report concerning emotion-  
ally disturbed youth.

SECTION.

20-46-106. Emotionally disturbed youth  
treated out of state.

20-46-105. Report concerning emotionally disturbed youth.

(a)(1) The Department of Human Services shall report monthly to the House Committee on Aging, Children and Youth, Legislative and Military Affairs and the Senate Interim Committee on Children and Youth or appropriate subcommittees thereof the number of children placed in residential and inpatient treatment programs, including sexual offender treatment, when Medicaid is the payment source.

(2) The monthly report shall include the following information:

(A) The total number of males and the total number of females placed in in-state residential programs and the total number of males and the total number of females placed in inpatient acute psychiatric programs, excluding sexual offender treatment programs, that were paid for by Medicaid during the previous month;

(B) The total number of males and the total number of females placed in out-of-state residential programs and the total number of males and the total number of females placed in inpatient acute psychiatric programs, excluding sexual offender treatment programs, that were paid for by Medicaid during the previous month;

(C) The total number of males and the total number of females placed in in-state residential and inpatient sexual offender treatment programs that were paid for by Medicaid during the previous month;

(D) The total number of males and the total number of females placed in out-of-state residential and inpatient sexual offender treatment programs that were paid for by Medicaid during the previous month;

(E) The total amount of money paid by Medicaid for the previous month for in-state residential and inpatient psychiatric programs with sexual offender treatment programs, residential and acute separately identified;

(F) The total amount of money paid by Medicaid for the previous month for out-of-state residential and inpatient psychiatric programs with sexual offender treatment programs, residential and acute separately identified;



(G) The total number of juveniles in residential and inpatient programs, including sexual offender treatment programs, that were paid for by Medicaid during the previous month;

(H) The total number of juveniles in residential and inpatient programs, including sexual offender treatment programs, that were paid for by Medicaid during the previous month, who are within fifty (50) miles of an Arkansas border; and

(I) The total number of juveniles in residential and inpatient programs, including sexual offender treatment programs, that were paid for by Medicaid during the previous month, who are more than fifty (50) miles from an Arkansas border.

(b) The report under this section shall include the number of placements for the previous month and the cumulative total number of placements for each fiscal year as of the date of the latest monthly report.

(c) The Legislative Council may request at any time that such additional information as it deems necessary be provided by the department.

(d) The deputy director of the appropriate division of the department as determined by the Director of the Department of Human Services shall certify by his or her signature that the information contained in these reports is correct to the best of his or her knowledge.

**History.** Acts 1985, No. 779, § 21; 1997, No. 179, § 31; 2003, No. 278, § 1; 2005, No. 1958, § 1; 2013, No. 1132, § 28.

**Amendments.** The 2013 amendment subdivided (a) into (a)(1) and (a)(2); reded-

icated former (a)(1) through (a)(9) as present (a)(2)(A) through (a)(2)(I); and in present (a)(1), substituted "Children and Youth" for "Children, and Youth" and deleted "Interim" following "the Senate."

## **20-46-106. Emotionally disturbed youth treated out of state.**

(a)(1) It is the intent of the General Assembly that treatment for emotionally disturbed youth within the State of Arkansas will result in higher quality care provided for less cost when compared with similar services delivered out of state.

(2) Prior to making an out-of-state placement, the Department of Human Services shall make and document the determinations established in subsection (b) of this section. If an out-of-state placement is made without documenting the determinations, payment for services shall not be authorized.

(3) The department shall provide a report monthly to the Senate Committee on Children and Youth and the House Committee on Aging, Children, and Youth, Legislative and Military Affairs reflecting the number of youths in the custody of the department receiving services out of state as follows:

(A) The total number of males and the total number of females currently in inpatient psychiatric programs, excluding sexual offender treatment programs; and

(B) The total number of males and the total number of females currently in inpatient psychiatric programs, including sexual offender treatment programs.

(b) Before an emotionally disturbed youth is placed in an out-of-state treatment facility, the department shall make and document the following determinations:

(1) Whether the emotionally disturbed youth has been appropriately and accurately diagnosed;

(2) Whether an appropriate treatment facility exists within the state;

(3) Whether there is an appropriate treatment facility in a border state;

(4) Whether the facility being considered has the most appropriate program;

(5) Whether the program requires payment of board, and if so, the amount;

(6) Whether the total cost for treatment in the out-of-state facility exceeds the cost for treatment in state;

(7) Where youth residing at the facility attend school, and whether the school is accredited;

(8) What type of professional staff is available at the facility;

(9) What mechanisms are in place to address problems that are not within the purview of the program;

(10) What other considerations exist in addition to the youth's emotional problems such as other medical conditions, travel expenses, wishes of the youth, best interests of the youth, effect of out-of-state placement on the youth, and proximity to the emotionally disturbed youth's family; and

(11) What alternatives exist to out-of-state placement and the benefits and detriments of each alternative.

(c) The determinations made under subsection (b) of this section shall be included in the youth's case file and shall be reviewed and considered by the juvenile court judge.

(d) The report shall also include the number of out-of-state placements by county, including court-ordered placements or private placements.

**History.** Acts 1989 (1st Ex. Sess.), No. 809, § 1; 1997, No. 312, § 15; 2005, No. 100, § 8; 1995, No. 765, § 1; 1995, No. 1958, § 2.

### SUBCHAPTER 3 — COMMUNITY MENTAL HEALTH CENTERS

#### SECTION.

20-46-301. Department of Human Services — Division of Behavioral Health Services — Powers and duties.

#### SECTION.

20-46-304. Minimum standards — Adoption.

20-46-306. Minimum standards — Purchasing procedures.



## SECTION.

20-46-307. Minimum standards — Records of purchases and service contracts.

20-46-308. Minimum standards — Periodic audits.

## SECTION.

20-46-315. Transfer of state's matching share.

### **20-46-301. Department of Human Services — Division of Behavioral Health Services — Powers and duties.**

(a) The Department of Human Services shall have the authority and power to create and maintain a Division of Behavioral Health Services and to provide services for community mental health clinics and centers, which shall be administered through such divisions, offices, sections, or units of the department as may be determined by the Director of the Department of Human Services.

(b) The department shall have the authority to establish or assist in the establishment and direction of those mental health clinics and centers in local and regional areas of the state which shall be operated under such divisions, offices, sections, or units of the department as may be determined by the director.

(c) The department, in cooperation with the Arkansas Building Authority, may sell, donate, lease on a short-term or long-term basis, or assign the use of any property and equipment owned by the department, including real property, furniture, fixtures, and office equipment and supplies, to those community mental health clinics and centers to assist them in the advancement of mental health in the state.

(d) The department shall engage in programs of mental health education in cooperation with the state's governmental units and established mental health education organizations, organized civic groups, lay organizations, and recognized mental health authorities, utilizing therefor the facilities of those organizations and groups for the advancement of mental health.

(e)(1) In the event that a state-operated community mental health center acquires private nonprofit status, the division shall have the authority to lease employees of the division to perform services for the private nonprofit community mental health center to ensure the continued delivery of satisfactory levels of mental health services consistent with the goals and objectives of the department and the division.

(2) The director shall have the authority to negotiate an employee leasing arrangement with the private nonprofit community mental health center as an on-going contract to perform mental health services for the center. The arrangement shall provide, at a minimum:

(A) For reimbursement for all leased division employee financial obligations with respect to wages, employment taxes, and employee benefits of each employee providing services for the center and for reimbursement of administrative costs associated with the leased employees;

(B) That all leased employees are covered by workers' compensation insurance provided in conformance with laws of the state and which may be provided by either the department or the center;

(C) That all leased employees shall be limited to providing services to clients or in support of clients which are consistent with the goals and objectives of the division and the department;

(D) That the division and the department shall not be vicariously liable for the liabilities of the center, whether contractual or otherwise;

(E) That the center shall provide liability insurance for the employees and indemnify the state for any actions of the employees; and

(F) That the leasing arrangement shall not be effective for a period of time to exceed each state fiscal biennium, and that payment and performance obligations of the arrangement are subject to the availability and appropriation of funds for the employees' salaries and other benefits.

(3) Employer responsibilities for leased employees shall be shared by the department and the community mental health center. The department shall be responsible for the administration and management of employee compensation and all employee benefit and welfare plans. The center may exercise day-to-day supervision and control of the employees' delivery of services in conformity with all division and department policies and procedures.

**History.** Acts 1971, No. 433, ch. 2, § 1; 1985, No. 348, § 7; A.S.A. 1947, § 59-301; Acts 1993, No. 410, § 2; 2005, No. 2009, § 1; 2013, No. 980, § 7; 2013, No. 1132, § 29; 2013, No. 1251, § 1.

**Amendments.** The 2013 amendment by No. 980 substituted "Behavioral" for "Mental" in (a).

The 2013 amendment by No. 1132 substituted "Behavioral Health" for "Mental

Health Services" in the introductory language; and substituted "Behavioral Health" for "Mental Health Services" in (a).

The 2013 amendment by No. 1251 substituted "may sell, donate," for "to sell, to lease" following "Arkansas Building Authority" and deleted "any and all kinds of" preceding "office equipment" in (c).

## 20-46-304. Minimum standards — Adoption.

(a)(1) The Division of Behavioral Health Services, shall adopt appropriate minimum standards of performance in the delivery of mental health services by community mental health centers.

(2) The standards shall include professional standards and accounting, statistical, and auditing standards.

(b) In addition, the division shall adopt reasonable minimum standards and requirements for conflict of interest policies and purchasing procedures for community mental health centers.

**History.** Acts 1985, No. 786, § 1; A.S.A. 1947, § 59-317; Acts 2013, No. 980, § 8.

**Amendments.** The 2013 amendment,

in (a), substituted "Behavioral" for "Mental" and designated subdivisions.



### **20-46-306. Minimum standards — Purchasing procedures.**

(a) The minimum standards prescribed by the Division of Behavioral Health Services for purchases by community mental health centers, so far as practicable, shall be comparable to the limits set for small purchases pursuant to the purchasing procedures established by the State Procurement Director and shall require competitive bidding for purchases exceeding those limits.

(b) However, the purchasing standards established by the division shall not require competitive bids for contracts for professional services in the health, medical, legal, and accounting fields, but shall require the contract entered into by a center to be approved by the chief executive officer and the governing board of the center.

(c) The standards promulgated by the department shall also require the center to maintain adequate documentation concerning procedures used and the justification for the awarding of the professional contracts.

**History.** Acts 1985, No. 786, § 3; A.S.A. 1947, § 59-319; Acts 2013, No. 980, § 9; 2013, No. 1132, § 30.

**Amendments.** The 2013 amendment by No. 980, in (a), substituted “Behavioral” for “Mental” and “competitive” for “competitive.”

The 2013 amendment by No. 1132 substituted “Behavioral Health” for “Mental Health Services” in the introductory language and (a); and in (a), deleted “shall” following “mental health centers,” inserted “shall,” and substituted “competitive” for “competitive.”

### **20-46-307. Minimum standards — Records of purchases and service contracts.**

(a) The minimum purchasing standards and procedures prescribed by the Division of Behavioral Health Services for community mental health centers shall not require preaudit or prepurchase approval by the state of purchases made by the centers but shall require all centers to maintain complete records regarding all such purchases and all professional services contracts entered into by the respective centers for a period of at least two (2) years and shall provide that the records shall be open for public inspection during that period.

(b) The division shall review the purchasing procedures and professional services contracts records of each mental health center on a random basis as a part of the regular certification site review to determine compliance with §§ 20-46-304 — 20-46-308.

**History.** Acts 1985, No. 786, § 4; A.S.A. 1947, § 59-320; Acts 2013, No. 980, § 10. substituted “Behavioral” for “Mental” in (a).

**Amendments.** The 2013 amendment

### **20-46-308. Minimum standards — Periodic audits.**

(a)(1) Each community mental health center shall undergo a periodic audit as may be required by the Division of Behavioral Health Services.

(2) Each audit shall reflect the compliance or noncompliance with the provisions of §§ 20-46-304 — 20-46-308.

(b) Each audit shall be furnished to the division and shall be subject to review by the Legislative Joint Auditing Committee and its staff.

(c) Nothing in §§ 20-46-304 — 20-46-308 shall repeal any authority which now exists for the Legislative Joint Auditing Committee and its staff to audit all or any part of the records of any community mental health center.

**History.** Acts 1985, No. 786, § 5; A.S.A. in (a), substituted “Behavioral” for “Men-  
1947, § 59-321; Acts 2013, No. 980, § 11. tal” and designated paragraphs as subdi-  
**Amendments.** The 2013 amendment, visions.

**20-46-315. Transfer of state’s matching share.**

The Division of Behavioral Health Services is authorized to retain and transfer to the Department of Human Services that portion of each community mental health center’s or clinic’s allotment which is required for the state’s matching share for payment to community mental health centers or clinics for services eligible for federal reimbursement under the programs administered by the department.

**History.** Acts 1987, No. 1053, § 14; **Amendments.** The 2013 amendment  
2013, No. 980, § 12. substituted “Behavioral” for “Mental.”

**SUBCHAPTER 5 — INTENSIVE RESIDENTIAL TREATMENT**

SECTION.

- 20-46-501. Purpose.
- 20-46-502. Definitions.
- 20-46-503. Authority to establish pro-  
gram.

SECTION.

- 20-46-504. Rules and regulations.
- 20-46-505. Procedures.

**20-46-501. Purpose.**

The purpose of this subchapter is to enable the Division of Behavioral Health Services to provide intensive residential treatment for adults with long-term severe mental illness within specialized mental health residential settings.

**History.** Acts 1987, No. 648, § 1; 2013, **Amendments.** The 2013 amendment  
No. 980, § 13. substituted “Behavioral” for “Mental.”

**20-46-502. Definitions.**

- As used in this subchapter, unless the context otherwise requires:
- (1)(A) “Adults with long-term severe mental illness” means a person, eighteen (18) years of age or over, who meets criteria for service eligibility as defined by the Division of Behavioral Health Services.
  - (B) Individuals whose sole disability results from alcoholism, drug abuse, or mental retardation are excluded from this definition; and
  - (2)(A) “Intensive residential treatment program” means a nonhospital establishment with permanent facilities which provides a twenty-four-hour program of care by qualified therapists, including, but not



limited to, licensed mental health professionals, psychiatrists, psychologists, psychotherapists, and licensed certified social workers for adults who have severe long-term mental illness but who are not in an acute phase of illness requiring the services of a psychiatric hospital, and who are in need of supervision or restorative treatment services.

(B) An establishment furnishing primarily domiciliary care is not within this definition.

**History.** Acts 1987, No. 648, § 2; 2013, in (1)(A), substituted “Behavioral” for “Mental” and designated paragraphs.

**Amendments.** The 2013 amendment,

**20-46-503. Authority to establish program.**

The Division of Behavioral Health Services is authorized to establish and maintain in a specialized mental health setting a program to provide intensive residential treatment for adults with long-term severe mental illness.

**History.** Acts 1987, No. 648, § 3; 2013, No. 980, § 13.

**Amendments.** The 2013 amendment substituted “Behavioral” for “Mental.”

**20-46-504. Rules and regulations.**

(a) The Division of Behavioral Health Services shall adopt, promulgate, and enforce the rules, regulations, and standards that may be necessary for the accomplishment of this subchapter.

(b) The rules, regulations, and standards shall be modified, amended, or rescinded from time to time by the division as may be in the public interest.

**History.** Acts 1987, No. 648, § 4; 2013, No. 980, § 13.

**Amendments.** The 2013 amendment substituted “Behavioral” for “Mental.”

**20-46-505. Procedures.**

The Division of Behavioral Health Services shall follow the procedures prescribed for adjudication in the Arkansas Administrative Procedure Act, § 25-15-201 et seq., in exercising any power authorized by this subchapter.

**History.** Acts 1987, No. 648, § 5; 2013, No. 980, § 13.

**Amendments.** The 2013 amendment substituted “Behavioral” for “Mental.”

**SUBCHAPTER 7 — PROVIDERS OF INDIGENT ASSISTANCE**

SECTION.

20-46-701. Authority — Scope.

20-46-702. Definitions.

SECTION.

20-46-703. Surveys of program providers.

**20-46-701. Authority — Scope.**

(a) Except when otherwise specified in federal law or regulation or state law, this subchapter shall be the exclusive state authority governing the survey process for psychiatric residential treatment facilities and outpatient mental health services programs.

(b) The scope of any survey or audit shall be limited to determining whether a facility is in compliance with applicable federal and state regulations.

**History.** Acts 2005, No. 1885, § 1.

**20-46-702. Definitions.**

(a) As used in this subchapter:

(1)(A) “Brief hold” means holding a resident without undue force for twenty (20) minutes or less in order to calm or comfort the resident.

(B) In no event shall a brief hold be construed as a personal restraint;

(2) “Department” means the Department of Human Services;

(3) “Director” means the Director of the Department of Human Services or his or her designee;

(4) “Program provider” means any psychiatric residential treatment facility for children or outpatient mental health services funded by a medical care program for indigents;

(5)(A) “Seclusion” means a behavior control technique involving the involuntary confinement of a resident in locked isolation.

(B) In no event shall verbal direction be construed as seclusion;

(6) “Serious injury” means any significant impairment of the physical condition of the resident whether self-inflicted or inflicted by someone else as determined by the provider’s qualified medical personnel, including, but not limited to:

(A) Burns;

(B) Lacerations;

(C) Bone fractures;

(D) Substantial hematoma; and

(E) Injuries to internal organs, whether self-inflicted or inflicted by someone else;

(7) “Serious occurrence” means a resident’s death, serious injury, or suicide attempt;

(8) “Suicide attempt” means any action taken by a resident for the purpose of inflicting death or serious injury to the resident as determined by the provider’s qualified medical personnel;

(9) “Survey” means any process by which compliance with federal law and regulations applicable to a program provider is determined;

(10) “Survey team” means an individual or individuals employed by or under contract with the department or its divisions; and

(11)(A) “Time-out” means a behavior management technique that involves the separation of a resident from other residents for a period

of time to a designated area from which the resident is not physically prevented from leaving.

(B) In no event shall a time-out be construed as a seclusion.

(C) In no event shall verbal direction be construed as time-out.

(b) The definitions in this section apply to any survey conducted upon any psychiatric residential treatment facility or outpatient mental health services funded by a medical care program for indigents.

**History.** Acts 2005, No. 1885, § 1.

### **20-46-703. Surveys of program providers.**

(a) The survey team shall:

(1) Conduct an exit conference during every survey;

(2) Allow electronic signatures and dates and dictated dates to serve as service delivery documentation;

(3) To the extent possible, conduct patient interviews in a manner that does not disrupt patient care or suggest a particular response from the interviewee;

(4) Conduct follow-up surveys on an accelerated schedule only upon a finding that a program provider is not in substantial compliance with applicable laws and regulations; and

(5)(A) Allow the program provider the option to submit to the surveyor within one (1) working day of an entrance interview a written summary of incident and accident reports instead of the actual reports.

(B) The requirements of subdivision (a)(5)(A) of this section shall not prevent the Department of Human Services from accessing all records related to the survey within any time frames established by federal law or regulation.

(b) A corrective action response shall be submitted to the survey team within thirty (30) days after the provider receives the report, but the time allowed for submitting the corrective action response shall be extended up to sixty (60) days upon request of the provider.

(c) For purposes of compliance with the state Medicaid program, program providers shall be prohibited from reporting serious occurrences to another entity other than the department and, if applicable, to the Centers for Medicare & Medicaid Services.

(d) The Director of the Department of Human Services shall ensure that the department complies with the Arkansas Administrative Procedure Act, § 25-15-201 et seq., and with § 20-77-107 in regard to all surveys of program providers.

**History.** Acts 2005, No. 1885, § 1.



## CHAPTER 47

### TREATMENT OF THE MENTALLY ILL

#### SUBCHAPTER.

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#### SUBCHAPTER 1 — GENERAL PROVISIONS

##### SECTION.

20-47-102. Officer's duty to make application to circuit court.

##### SECTION.

20-47-108. [Repealed.]

#### 20-47-102. Officer's duty to make application to circuit court.

Whenever any sheriff, coroner, or constable shall discover any person to be of unsound mind who resides in the county, it shall be his or her duty to make application to the circuit court for the exercise of its jurisdiction, and thereupon the like proceedings shall be had as directed in § 20-47-103.

**History.** Rev. Stat., ch. 78, § 3; C. & M. Dig., § 5830; Pope's Dig., § 7547; A.S.A.

1947, § 59-104; Acts 2003, No. 1185, § 256.

#### 20-47-108. [Repealed.]

**Publisher's Notes.** This section, concerning the care of insane paupers, was repealed by Acts 2005, No. 441, § 1. The

section was derived from Acts 1859, No. 52, § 1; C. & M. Dig., § 5879; Pope's Dig., § 7601; A.S.A. 1947, § 59-113.

#### SUBCHAPTER 2 — COMMITMENT AND TREATMENT

##### SECTION.

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**Effective Dates.** Acts 2003, No. 1473, § 74: July 1, 2003. Emergency clause provided: "It is found and determined by the General Assembly of the State of Arkansas that this act includes technical corrects to Act 923 of 2003 which establishes the classification and compensation levels of state employees covered by the provisions of the Uniform Classification and Compensation Act; that Act 923 of 2003 will become effective on July 1, 2003; and that to avoid confusion this act must also be effective on July 1, 2003. Therefore, an emergency is declared to exist and this act being necessary for the preservation of the public peace, health, and safety shall become effective on July 1, 2003."

Acts 2007, No. 463, § 6: July 1, 2007. Emergency clause provided: "It is found

and determined by the General Assembly of the State of Arkansas that federal law prohibits the sale of firearms to persons who have been committed to a mental institution; that it is the intent of this act to require the submission of information to create a confidential database that may only be used for firearm sales or transactions; and that this act is necessary because possession of a firearm by a person that is suicidal, homicidal, or gravely disabled poses an critical threat of harm to the citizens of this state. Therefore, an emergency is declared to exist and this act being necessary for the preservation of the public peace, health, and safety shall become effective on July 1, 2007."

## 20-47-201. Purpose — Policy.

(a) The purpose of this subchapter is to enable the Division of Behavioral Health Services to assist in:

(1) Establishing, maintaining, and coordinating a comprehensive and effective system of services for persons with mental illness, disease, or disorder who may be voluntarily or involuntarily admitted to mental health facilities and programs within the state;

(2) Reducing the occurrence, severity, and duration of mental disabilities; and

(3) Preventing persons with mental illness from harming themselves or others.

(b) It is the policy of this state to provide access for persons with severe mental illness to appropriate, adequate, and humane care which, to the extent possible while meeting the purposes of rehabilitation and treatment, is:

(1) Within each person's own geographic area of residence;

(2) Least restrictive of the person's freedom of movement and ability to function normally in society, while being appropriate to the individual's capacity and promoting the person's independence; and

(3) Directed toward assuring movement through all treatment components to assure continuity of care.

(c) It is the policy of this state to maintain involuntary admission laws to ensure that mental illness, disease, or disorder in and of itself is insufficient to involuntarily admit any person into the mental health services system.

**History.** Acts 1989, No. 861, § 27; 2013, No. 980, § 14.

substituted "Behavioral" for "Mental" in the introductory language of (a).

**Amendments.** The 2013 amendment

**20-47-202. Definitions.**

As used in this subchapter:

(1) "Administrator" means the chief administrative officer or executive director of any private or public facility or of any community mental health center certified by the Division of Behavioral Health Services;

(2) "Behavior history" means a person's statements or actions on specific occasions as established by the person's declarations, observations of others, or records;

(3) "Community mental health center" means a program and its affiliates established and administered by the state, or a private, nonprofit corporation certified by the division for the purpose of providing mental health services to the residents of a defined geographic area and which minimally provides twenty-four-hour emergency, inpatient, outpatient, consultation, education, prevention, partial care, follow-up and aftercare, and initial screening and precare services. The division may contract with a community mental health center for the operation and administration of any services which are part of the state mental health system;

(4) "Crisis response services" means immediate or emergency treatment. Because mental illnesses are often of an episodic nature, there will be instances that require acute and quick crisis response services;

(5) "Deputy director" means the chief executive officer for the Division of Behavioral Health Services;

(6) "Detention" means any confinement of a person against his or her wishes and begins either:

(A) When a person is involuntarily brought to a receiving facility or program or to a hospital;

(B) When, pursuant to § 20-47-209(a), the person appears for the initial hearing; or

(C) When a person on a voluntary status in a receiving facility or program or a hospital requests to leave pursuant to § 20-47-204(3);

(7) "Division" means the Division of Behavioral Health Services;

(8) "Hospital" means the University of Arkansas for Medical Sciences Hospital, the federal Department of Veterans Affairs hospitals, or any private hospital with a fully trained psychiatrist on the active or consultant staff;

(9) "Initial screening" means initial screening services conducted by a mental health professional provided by a receiving facility or program for individuals residing in the area served by the receiving facility or program who are being considered for referral to inpatient programs of the state mental health system to determine whether or not the individual meets the criteria for voluntary or involuntary admission and to determine whether or not appropriate alternatives to institutionalization are available. These screening services shall be available to community organizations, agencies, or private practitioners who are involved in making referrals to the state mental health system;

(10) "Involuntary admission" means:



(A) Court-ordered admission to twenty-four-hour inpatient health care;

(B) Immediate confinement under § 20-47-210; or

(C) Admission to outpatient behavioral health care services furnished by a receiving facility or program or a behavioral health care clinic certified by the Division of Behavioral Health Services;

(11) "Least restrictive appropriate setting" for treatment means the available treatment setting which provides the person with the highest likelihood of improvement or cure and which is not more restrictive of the person's physical or social liberties than is necessary for the most effective treatment of the person and for adequate protection against any dangers which the person poses to himself or herself or others;

(12)(A) "Mental illness" means a substantial impairment of emotional processes, or of the ability to exercise conscious control of one's actions, or the ability to perceive reality or to reason, when the impairment is manifested by instances of extremely abnormal behavior or extremely faulty perceptions.

(B) It does not include impairment solely caused by:

(i) Epilepsy;

(ii) Mental retardation;

(iii) Continuous or noncontinuous periods of intoxication caused by substances such as alcohol or drugs; or

(iv) Dependence upon or addiction to any substance such as alcohol or drugs;

(13) "Physician" means a medical doctor licensed to practice in Arkansas;

(14) "Psychosurgery" means those operations currently referred to as lobotomy, psychiatric surgery, and behavioral surgery and all other forms of brain surgery if the surgery is performed for the purpose of the following:

(A) Modification or control of thoughts, feelings, actions, or behavior rather than the treatment of a known and diagnosed physical disease of the brain;

(B) Modification of normal brain function or normal brain tissue in order to control thoughts, feelings, actions, or behavior; or

(C) Treatment of abnormal brain function or abnormal brain tissue in order to modify thoughts, feelings, actions, or behavior when the abnormality is not an established cause of those thoughts, feelings, actions, or behavior;

(15) "Receiving facility or program" means an inpatient or outpatient treatment facility or program which is designated within each geographic area of the state by the Deputy Director for the Division of Behavioral Health Services to accept the responsibility for care, custody, and treatment of persons involuntarily admitted to the state mental health system;

(16)(A) "Resides" means a person's ongoing physical presence in the state together with indications that the person's presence in the state is something other than merely transitory.

(B) “Resides” includes a temporary absence from the state or temporary physical presence in a city that adjoins the Arkansas state line or is separated only by a navigable river from an Arkansas city that adjoins the Arkansas state line;

(17)(A) “Restraint” means any manual method, physical or mechanical device, material, or equipment that immobilizes a person or reduces the ability of a person to move his or her arms, legs, body, or head freely.

(B) “Restraint” does not include devices such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a person for the purpose of protecting the person from falling or to permit the person to participate in activities without the risk of physical harm to himself or herself;

(18) “State mental health system” means the Arkansas State Hospital, the George W. Jackson Community Mental Health Center in Jonesboro, and any other facility or program licensed or certified by the Division of Behavioral Health Services;

(19) “State or local authority” means a state or local government authority or agency or a representative of a state or local government authority or agency acting in an official capacity;

(20) “Treatment” means those psychological, educational, social, chemical, medical, somatic, or other techniques designed to bring about rehabilitation of persons with mental illness. Treatment may be provided in inpatient and outpatient settings; and

(21) “Treatment plan” means an individualized written document developed by the treatment staff of the hospital or receiving facility or program which includes the following:

(A) A substantiated diagnosis in the terminology of the American Psychiatric Association’s Diagnostic and Statistical Manual;

(B) Short-term and long-term treatment goals;

(C) Treatment programs, facilities, and activities to be utilized to achieve the treatment goals; and

(D) Methods for periodic review and revision of the treatment plan.

**History.** Acts 1989, No. 861, § 1; 1993, No. 410, § 1; 2003, No. 1473, § 41; 2003, No. 1789, § 1; 2007, No. 636, § 3; 2011, No. 823, § 1; 2013, No. 573, § 1.

**A.C.R.C. Notes.** Acts 2013, No. 573, § 3, provided:

“(a) This act applies only to a reciprocal agreement between an Arkansas state agency and an agency of another state that is entered into on or after the effective date of this act.

“(b) A reciprocal agreement entered

into between an Arkansas state agency and an agency of another state before the effective date of this act is governed by the law in effect on the date the reciprocal agreement was entered into, and the former law is continued in effect for that purpose.”

**Amendments.** The 2011 amendment added (19)[10].

The 2013 amendment added (16) and (19) and renumbered the remaining subdivisions accordingly.



**CASE NOTES**

**Cited:** Gibson v. State, 89 Ark. App. 184, 201 S.W.3d 422 (2005).

**20-47-204. Voluntary admissions.****CASE NOTES****Change of Status.**

Defendant state health care professionals owed no Fourteenth Amendment Due Process-level duty of care to a voluntary mental health facility patient, and even if her removal from suicide watch 3 days before she hanged herself and subdivision (2) of this section and § 20-47-210(c), gave

her involuntary status, plaintiff administratrix of her estate's Due Process claim failed because upon being discovered, she was no different than any unconscious patient in an emergency room and simple or professional negligence standards applied. *Shelton v. Ark. Dep't of Human Servs.*, 677 F.3d 837 (8th Cir. 2012).

**20-47-205. Jurisdiction of circuit court.**

(a) The circuit courts of this state shall have exclusive jurisdiction of the involuntary admission procedures initiated pursuant to this subchapter.

(b)(1) Within seven (7) days of the person's detention, excluding weekends and holidays, the court shall conduct the hearing as defined in § 20-47-214.

(2) Except as otherwise provided in subsection (d) of this section, the hearing, as defined by §§ 20-47-214 and 20-47-215, shall be conducted by the same court, or by a judge designated on exchange, who heard the original petition and issued the appropriate order.

(3) The court shall ensure that the person sought to be involuntarily admitted is afforded all his or her rights as prescribed by this subchapter.

(4) The circuit judge, when conducting any hearing set out in this subchapter, may conduct the hearing within any county of the judge's judicial district.

(c) The hearings conducted pursuant to §§ 20-47-209, 20-47-214, and 20-47-215 may be held at inpatient programs of the state mental health system or a receiving facility or program where the person is detained.

(d) A circuit judge of the Sixth Judicial District sitting within the Sixth Judicial District may conduct involuntary commitment hearings prescribed by §§ 20-47-214 and 20-47-215 and initiated in other judicial districts of this state pursuant to §§ 20-47-207 and 20-47-209 provided that the person sought to be committed is detained within the boundaries of the Sixth Judicial District at the time of the hearing held pursuant to §§ 20-47-214 or 20-47-215. The Sixth Judicial District shall thus assume the mantle of other judicial districts and shall have the authority to enter treatment orders for other judicial districts in the hearings prescribed by §§ 20-47-214 and 20-47-215. In those cases, no initial petition pursuant to § 20-47-207 shall be filed in the Sixth

Judicial District but only in the court of original jurisdiction. Provided, however, if the person was transported to a location within the Sixth Judicial District by order of a court outside the Sixth Judicial District, the court of original jurisdiction may conduct the hearings prescribed by §§ 20-47-214 and 20-47-215.

**History.** Acts 1989, No. 861, § 2; 1989 1224, § 1; 1999, No. 1245, § 1; 2003, No. (3rd Ex. Sess.), No. 28, § 4; 1997, No. 1185, § 257.

### **20-47-207. Involuntary admission — Original petition.**

(a) **WRITTEN PETITION — VENUE.** Any person having reason to believe that a person meets the criteria for involuntary admission as defined in subsection (c) of this section may file a verified petition with the probate clerk of the county in which the person alleged to have mental illness resides or is detained.

(b) **CONTENTS OF PETITION.** The petition for involuntary admission shall:

(1) State whether the person is believed to be of danger to himself or herself or others as defined in subsection (c) of this section;

(2) Describe the conduct, clinical signs, and symptoms upon which the petition is based. The description shall be limited to facts within the petitioner's personal knowledge;

(3) Contain the names and addresses of any witnesses having knowledge relevant to the allegations contained in the petition; and

(4) Contain a specific prayer for involuntary admission of the person to a hospital or to a receiving facility or program for treatment pursuant to § 20-47-218(c).

(c) **INVOLUNTARY ADMISSION CRITERIA.** A person shall be eligible for involuntary admission if he or she is in such a mental condition as a result of mental illness, disease, or disorder that he or she poses a clear and present danger to himself or herself or others:

(1) As used in this subsection, "a clear and present danger to himself or herself" is established by demonstrating that:

(A) The person has inflicted serious bodily injury on himself or herself or has attempted suicide or serious self-injury, and there is a reasonable probability that the conduct will be repeated if admission is not ordered;

(B) The person has threatened to inflict serious bodily injury on himself or herself, and there is a reasonable probability that the conduct will occur if admission is not ordered;

(C) The person's recent behavior or behavior history demonstrates that he or she so lacks the capacity to care for his or her own welfare that there is a reasonable probability of death, serious bodily injury, or serious physical or mental debilitation if admission is not ordered;  
or

(D)(i) The person's understanding of the need for treatment is impaired to the point that he or she is unlikely to participate in treatment voluntarily;



(ii) The person needs mental health treatment on a continuing basis to prevent a relapse or harmful deterioration of his or her condition; and

(iii) The person’s noncompliance with treatment has been a factor in the individual’s placement in a psychiatric hospital, prison, or jail at least two (2) times within the last forty-eight (48) months or has been a factor in the individual’s committing one (1) or more acts, attempts, or threats of serious violent behavior within the last forty-eight (48) months; and

(2) As used in this subsection, “a clear and present danger to others” is established by demonstrating that the person has inflicted, attempted to inflict, or threatened to inflict serious bodily harm on another, and there is a reasonable probability that the conduct will occur if admission is not ordered.

**History.** Acts 1989, No. 861, §§ 1, 4; 2003, No. 1789, § 2; 2007, No. 1416, § 1; 2009, No. 680, § 1.

**Amendments.** The 2009 amendment deleted “initially” preceding “detained” in (a).

RESEARCH REFERENCES

**ALR.** Validity, Construction, and Application of Overt Act Requirement of State Statutes Providing for Commitment of Sexually Dangerous Persons. 56 A.L.R.6th 647.

20-47-210. Immediate confinement — Initial evaluation and treatment.

RESEARCH REFERENCES

**ALR.** Validity, Construction, and Application of Overt Act Requirement of State Statutes Providing for Commitment of Sexually Dangerous Persons. 56 A.L.R.6th 647.

CASE NOTES

**Due Process.** Defendant state health care professionals owed no Fourteenth Amendment Due Process-level duty of care to a voluntary mental health facility patient, and even if her removal from suicide watch 3 days before she hanged herself and § 20-47-204(2) and subsection (c) of this section gave her involuntary status, plaintiff administratrix of her estate’s Due Process claim failed because upon being discovered, she was no different than any unconscious patient in an emergency room and simple or professional negligence standards applied. *Shelton v. Ark. Dep’t of Human Servs.*, 677 F.3d 837 (8th Cir. 2012).

20-47-214. Forty-five-day involuntary admission — Hearing.

- (a)(1) Within the period specified in § 20-47-205, a hearing shall be held.

(2) The hearing must be conducted in public, open to the news media.

(3) All testimony must be taken under oath and preserved.



(4) All witnesses shall be subject to a penalty for perjury, and each witness who shall testify shall be instructed by the hearing officer as to the penalty for perjury prior to testifying.

(b)(1) Should any person be found guilty of giving false testimony that results in a person's wrongful involuntary admission, he or she shall be liable for civil damages and subject to incarceration for not less than thirty (30) days.

(2) The court shall make a determination at that time whether clear and convincing evidence has been presented that the person sought to be involuntarily admitted is of danger to himself or herself or to others as defined in § 20-47-207.

(3) If this burden of proof has been met, the court shall issue an order authorizing the hospital or receiving facility or program to detain the person for treatment for a maximum of forty-five (45) days.

(c) This section shall be construed to allow the person sought to be involuntarily admitted to request treatment under the least restrictive alternative appropriate setting.

(d) If a hearing pursuant to this section is not held within the period specified in § 20-47-205, the person shall be released.

(e) Upon filing of an order of commitment issued under subdivision (b)(3) of this section with a circuit clerk or a probate clerk, the circuit clerk or probate clerk shall submit a copy of the order of commitment to the Arkansas Crime Information Center.

**History.** Acts 1989, No. 861, § 9; 2007, No. 463, § 4.

### **20-47-215. Additional periods of involuntary admission — Petitions — Hearing.**

(a) **GENERALLY.**

(1) Additional one hundred eighty-day involuntary admission orders may be requested if, in the opinion of the treatment staff, a person involuntarily admitted continues to meet the criteria for involuntary admission.

(2) Additional one hundred eighty-day involuntary admission periods may be requested by the treatment staff if it is the opinion of the treatment staff that the person needs continued treatment and supervision without which the person poses a likelihood of danger to himself or herself or to others as defined in § 20-47-207 if discharged.

(3) The treatment staff may request additional involuntary admission orders as they are deemed necessary.

(b) **PROCEDURE.**

(1)(A) A request for periods of additional involuntary admission under this section shall be made by a petition verified by a member of the treatment staff.

(B) The petition shall set forth the facts and circumstances forming the basis for the request.

(2) Upon the filing of a petition for additional involuntary admission, all rights enumerated in §§ 20-47-211 and 20-47-212 shall be applicable.

(c) HEARING.

(1)(A) A hearing on the petition seeking additional involuntary admission pursuant to this section must be held before the expiration of the period of involuntary admission.

(B) The hearing shall be open to the public and the news media, unless the person sought to be additionally involuntarily admitted shall request in writing that the hearing be closed.

(C) All written requests filed on behalf of the person sought to be additionally involuntarily admitted must be witnessed by the attorney who is representing the person.

(2) All testimony shall be recorded under oath and preserved.

(3) The need for additional involuntary admission shall be proven by clear and convincing evidence.

(d) NEW ORIGINAL PETITION. Nothing in this section shall prevent a new original petition from being filed subsequent to the release of a person involuntarily admitted pursuant to this subchapter.

(e) Upon filing of an order of commitment issued under this section with a circuit clerk or a probate clerk, the circuit clerk or probate clerk shall submit a copy of the order of commitment to the Arkansas Crime Information Center.

**History.** Acts 1989, No. 861, § 10; 2007, No. 463, § 5; 2011, No. 823, § 2.

**A.C.R.C. Notes.** Because of an apparent error in the engrossment of Acts 2007, No. 463, the following language was included in Section 5 of that act: “(2) Upon filing of an order under § 5-2-310(b) or an order of commitment entered pursuant to

§§ 5-2-314(b), 20-47-214, or 20-47-215 with a circuit”.

**Amendments.** The 2011 amendment substituted “a member of the treatment staff” for “the psychiatrist of the hospital or receiving facility or program” in present (b)(1)(A).

RESEARCH REFERENCES

**ALR.** Validity, Construction, and Application of Overt Act Requirement of State Statutes Providing for Commitment of

Sexually Dangerous Persons. 56 A.L.R.6th 647.

20-47-225. Liability for charges.

(a) Notwithstanding any statute enacted before January 1, 2011, receiving facilities and programs and the Arkansas State Hospital may make charges for patient treatment.

(b) Persons legally liable for the support for a patient are liable jointly and severally with the patient and the estate of the patient for treatment charges.

(c) Patient treatment charges may not exceed the actual cost of treatment.

(d)(1) The Division of Behavioral Health Services shall promulgate rules establishing reasonable charges that may be made by receiving facilities, programs, and the Arkansas State Hospital.

(2) Rules establishing reasonable charges shall:

(A) Provide for postponing the collection of charges based on clinical considerations or the patient's inability to pay, or both; and

(B) Waive charges for treatment of defendants who plead guilty or nolo contendere or are found guilty at trial.

**History.** Acts 1989, No. 861, § 21; 2011, No. 991, § 4.

**Amendments.** The 2011 amendment rewrote the section.

### **20-47-228. Assurance of compliance.**

(a) To assure compliance under this subchapter, the Division of Behavioral Health Services, through its authorized agents, may visit or investigate any state mental health system program or facility to which persons are voluntarily or involuntarily admitted under this subchapter.

(b) The division shall by July 1 of each year designate receiving facilities and programs within prescribed geographic areas of the state for purposes of voluntary admissions or involuntary commitments under this subchapter and establish ongoing mechanisms for review and refinement of the state mental health system.

**History.** Acts 1989, No. 861, § 26; 2013, No. 980, § 15.

substituted "Behavioral" for "Mental" in (a).

**Amendments.** The 2013 amendment

### **20-47-229. Restraint of an Arkansas State Hospital patient.**

(a) If necessary for security, an Arkansas State Hospital patient shall be physically restrained with a restraint while being transported to locations away from hospital grounds or to and from any court appearance.

(b) A patient shall not be physically restrained with a restraint if the restraint is medically contraindicated.

(c) The restraint shall be implemented in accordance with safe and appropriate restraint types and restraint techniques as determined by hospital policy.

(d) The restraint used shall be the least restrictive type or technique necessary to effectively protect the patient, staff members, or others from harm.

(e) The restraint shall not be used as a means of coercion, discipline, convenience, or retaliation by staff.

**History.** Acts 2007, No. 636, § 4; 2009, No. 952, § 8.

substituted "restraint types and restraint techniques" for "restraint and techniques"

**Amendments.** The 2009 amendment in (c).



**20-47-230. Return of detained or involuntarily admitted person to state of residence — Reciprocal agreements.**

(a) The Department of Human Services may enter into a reciprocal agreement with a state that adjoins the Arkansas state line or is separated only by a navigable river from the Arkansas state line to facilitate the return of a person who is detained in or involuntarily admitted to mental health facilities in this state or another state to the state of his or her residence.

(b) The state returning a detained or involuntarily admitted person to another state shall bear the expenses of returning the person, unless the state agrees to share costs under a reciprocal agreement made under subsection (a) of this section.

(c) If a state or local authority of another state petitions the department, the department shall enter into a reciprocal agreement with the state or local authority to facilitate the return of a person who is detained in or involuntarily admitted to a receiving facility in this state to the state of his or her residence unless the department determines that the terms of the agreement are not acceptable.

(d)(1) A reciprocal agreement entered into by the department under subsection (a) of this section shall require the department to develop a process for returning a person who is detained in or involuntarily admitted to a receiving facility to the person's state of residence.

(2) A process developed under subdivision (d)(1) of this section shall:

(A) Provide suitable care for the person who is detained in or involuntarily admitted to a mental health facility;

(B) Use available resources efficiently; and

(C) Consider commitment to a proximate mental health facility to make possible the return of the detained or involuntarily admitted person to his or her state of residence.

(e) The department shall coordinate the reciprocal agreement and the process developed under subsection (d) of this section with a mental health facility, mental hospital, health service provider, court, or law enforcement agency located in Arkansas.

**History.** Acts 2013, No. 573, § 2.

**A.C.R.C. Notes.** Acts 2013, No. 573, § 3, provided:

“(a) This act applies only to a reciprocal agreement between an Arkansas state agency and an agency of another state that is entered into on or after the effective date of this act.

“(b) A reciprocal agreement entered into between an Arkansas state agency and an agency of another state before the effective date of this act is governed by the law in effect on the date the reciprocal agreement was entered into, and the former law is continued in effect for that purpose.”

**SUBCHAPTER 3 — RESIDENTIAL CARE FACILITIES**

## SECTION.

20-47-301. Legislative findings and intent.

20-47-302. [Repealed.]

## SECTION.

20-47-303. Multihour daily service rate reimbursement.

**20-47-301. Legislative findings and intent.**

(a)(1) The General Assembly recognizes that the state encouraged the placement of mentally ill residents into residential care facilities over a decade ago and has taken various approaches to funding since then. The General Assembly also recognizes that there are inherent problems with the current system that create disincentives for proper care and physical environments.

(2) The General Assembly further recognizes that:

(A) Individuals with developmental disabilities living in group homes, community residential housing, and apartments operated by nonprofit community programs as defined in § 20-48-101 face many of the same challenges in receiving proper care and assistance with activities of daily living as individuals with mental illness living in residential care facilities;

(B) An individual with mental illness who is Medicaid-eligible and lives in a residential care facility can receive Medicaid congregate-setting personal care services to assist with activities of daily living while an individual with developmental disabilities who is Medicaid-eligible and lives in a group home, community residential housing, or apartment operated by a nonprofit community program as defined in § 20-48-101 is not able to receive similar services through the Medicaid Personal Care Program; and

(C) This inequity must be corrected in order to provide equal access to Medicaid congregate-setting personal care services for individuals with developmental disabilities.

(b) The purpose of this subchapter is to provide short-term solutions and long-term solutions to the problem of caring for individuals with mental illness, elderly persons, and other residents in residential care facilities and assisted living facilities and individuals with developmental disabilities living in group homes, community residential housing, and apartments operated by nonprofit community programs as defined in § 20-48-101.

**History.** Acts 1999, No. 1421, § 1; 2011, No. 1156, § 1.

**Amendments.** The 2011 amendment inserted (a)(2), and redesignated previously undesignated text as present (a)(1)

and (b); and, in (b), substituted “individuals with mental illness” for “mentally ill persons” and added “and assisted living facilities ... as defined in § 20-48-101.”



**20-47-302. [Repealed.]**

**Publisher's Notes.** This section, concerning the establishment of a task force on residential mental health care, was repealed by Acts 2013, No. 1145, § 2. This section was derived from Acts 1999, No. 1421, § 2.

**20-47-303. Multihour daily service rate reimbursement.**

(a) As used in this section:

(1) "Congregate setting" means a location within a residential care facility, an assisted living facility, or a designated residential setting of a nonprofit community program as defined in § 20-48-101 or its nonprofit affiliates;

(2) "Designated residential setting" includes the following when operated by a nonprofit community program as defined in § 20-48-101:

(A) A group home for individuals with developmental disabilities in operation and licensed by the Division of Developmental Disabilities Services of the Department of Human Services on or before July 1, 1995;

(B) A community residential home established after July 1, 1995, that serves individuals with developmental disabilities and provides housing for no more than four (4) unrelated persons; or

(C) An apartment complex established after July 1, 1995, that serves individuals with developmental disabilities; and

(3)(A) "Intermediate care facility for individuals with developmental disabilities" means a residential institution maintained for the care and training of individuals with developmental disabilities, including without limitation individuals with intellectual disabilities.

(B) "Intermediate care facility for individuals with developmental disabilities" has the same meaning as "intermediate care facility for the mentally retarded" or "ICF/MR" under federal law.

(b)(1)(A) The Department of Human Services shall reimburse residential care facilities, assisted living facilities, and qualified nonprofit community programs with a multihour daily service rate for personal care services delivered in congregate settings as provided in this section and approved by the Centers for Medicare & Medicaid Services.

(B) The application of subdivision (b)(1)(A) to nonprofit community programs is subject to available funds.

(2) The department shall maintain Medicaid provider regulations appropriate for the delivery of personal care services in congregate settings and the related multihour daily service rate reimbursement methodology.

(3) The department shall make best efforts to obtain and maintain approval for a multihour daily service rate reimbursement for personal care services delivered in congregate settings from the Centers for Medicare & Medicaid Services.

(c) The department shall provide copies to the Administrative Rules and Regulations Committee of the Legislative Council, providers, and



the public of all state plan amendments, documentation, and correspondence submitted to or received from the Centers for Medicare & Medicaid Services in regard to this section and shall work jointly with provider representatives in obtaining and maintaining approval for a multihour daily service rate for personal care services delivered in congregate settings from the Centers for Medicare & Medicaid Services.

(d)(1) The Division of Medical Services of the Department of Human Services shall use the same multihour daily service rate reimbursement methodology for personal care services delivered in a congregate setting located in a designated residential setting of a nonprofit community program as defined in § 20-48-101 as for personal care services delivered in a congregate setting located in a residential care facility and an assisted living facility.

(2) Reimbursement for personal care services under this section is not available to an individual with a developmental disability who resides in an intermediate care facility for individuals with developmental disabilities.

**History.** Acts 1999, No. 1421, § 3; 2011, No. 560, § 1; 2011, No. 1156, § 2.

**A.C.R.C. Notes.** Pursuant to § 1-2-207, § 20-47-303 is set out above as amended by Acts 2011, No. 1156, § 2. Former subsection (a) of § 20-47-303 was also amended by Acts 2011, No. 560, § 1, to read as follows: “(a)(1) The Department of Human Services shall reimburse residential care facilities and assisted living facilities for Medicaid personal care services on a per diem basis, subject to approval by the Centers for Medicare and Medicaid Services, and shall develop Medicaid provider regulations appropriate for a congregate setting and per diem reimbursement.”

“(2) The department shall make the best efforts to obtain approval from the administration Centers for Medicare and Medicaid Services.”

**Amendments.** The 2011 amendment rewrote the section heading, inserted present (a) and redesignated the remaining subsections accordingly; rewrote present (b); in present (c), substituted “the Centers for Medicare and Medicaid Services” for “the administration,” substituted “obtaining and maintaining approval” for “seeking administration approval,” and added “for a multi-hour ... Centers for Medicare and Medicaid Services”; and added (d).

## SUBCHAPTER 4 — COOPERATION AMONG INSTITUTIONS

### SECTION.

20-47-405. Tubercular mental patients —  
Transfer.

### 20-47-405. Tubercular mental patients — Transfer.

(a) Any person who is committed to the Arkansas State Hospital for treatment of a mental disease and who has or who develops tuberculosis may be transferred to a private hospital for treatment of his or her tuberculosis in the discretion of the Director of the Arkansas State Hospital.

(b) The person so transferred shall be returned to the Arkansas State Hospital when his or her tuberculosis has improved to the point where it is not dangerous to himself or herself or others.

**History.** Acts 1971, No. 433, ch. 3, § 27;  
A.S.A. 1947, § 59-427; Acts 2005, No. 440,  
§ 1.

**SUBCHAPTER 5 — CHILD AND ADOLESCENT SERVICE SYSTEM PROGRAM**

SECTION.

- 20-47-502. Definitions.
- 20-47-505. Child and Adolescent Service System Program Coordinating Council.
- 20-47-506. Regional Child and Adolescent Service System Program Coordinating Council planning teams.

SECTION.

- 20-47-507. Child and Adolescent Service System Program Coordinating Council staff.
- 20-47-510. Coordination and oversight — Annual reports.

**20-47-502. Definitions.**

As used in this subchapter:

(1)(A) “Case management” means those efforts that ensure that necessary services for the child and family are obtained and monitored.

(B) Such efforts shall include coordination across agencies for evaluations, the provision of services based on assessments and evaluations that result in the development of an interagency service plan, the review for adequacy of services through client progress, and maintaining cooperation among agencies;

(2)(A) “Case review” means a multiagency effort to design and provide a service delivery plan for difficult-to-serve children who may require unusual services or service configurations.

(B) When utilizing a group process for reaching service delivery decisions, the group shall be composed of those who carry sufficient authority to ensure timely provision of services;

(3) “CASSP” means the Child and Adolescent Service System Program;

(4) “Child with emotional disturbance” means an individual who has been diagnosed with a mental, behavioral, or emotional disorder of a long-term nature under the age of eighteen (18) or under the age of twenty-one (21) if program services began before the age of eighteen (18):

(A) Who is exhibiting inappropriate emotional, interpersonal, or behavioral problems within the home, preschool program, school, or community given his or her age, intellectual level, and cultural background;

(B) Whose degree of dysfunction is at least disruptive and often disabling;

(C) Whose problems persist after efforts to deal with the problems have been made by significant others in the child’s social environment;

(D) Who meets specific criteria established by the Child and Adolescent Service System Program Coordinating Council; and



(E) Who has multiagency needs exhibited by one (1) or more of the following characteristics:

(i) The behavior occurs with a sufficient frequency to be considered a pattern of response or to be so intense that the consequences lead to a severe measure of control, including, but not limited to:

- (a) Seclusion;
- (b) Restraint;
- (c) Hospitalization; or
- (d) Chemical intervention;

(ii) The behavior, although provoked, is judged to be extreme or inappropriate for the age, including, but not limited to:

- (a) Very aggressive; or
- (b) Self-withdrawn;

(iii) The behavior is sufficiently disruptive as to lead to exclusion from school, home, therapeutic, or recreational settings; or

(iv) The behavior is sufficiently intense or severe to be considered seriously detrimental to the child's growth, development, or welfare or seriously detrimental to the safety or welfare of others.

(5) "Comprehensive Children's Behavioral Health System of Care Plan" means a plan to assist the Division of Behavioral Health Services in providing oversight for the Child and Adolescent Service System Program;

(6)(A) "Flexible funds" means a specific fiscal allocation designated for atypical expenditures to meet extraordinary needs of a child and family identified in the multiagency plan of services.

(B) Decisions for expenditure of flexible funds shall be made at the regional or local level and shall be approved by all involved service providers;

(7) "Multiagency plan of services" means the integrated, individualized plan of care that is developed through the collaboration of all agencies providing services for that child and based on evaluations shared by each involved agency with the Child and Adolescent Service System Program local service team;

(8)(A) "Regional plan" means a written strategy developed by regional program teams that specifies the kind, mix, and priority of services to be provided in each community mental health center catchment area.

(B) The regional plan shall:

- (i) Address all components of the system of care;
- (ii) Be based on the principles for the system of care provided in this section and on the service needs of the children with emotional disturbance in the region;
- (iii) Include procedures for evaluating services provided to children with emotional disturbance and their families;
- (iv) Be reviewed annually by the council; and
- (v) Upon approval be incorporated into the statewide plan;

(9) "Screening and assessment" means an initial appraisal of a child identified or suspected of having emotional disturbance that provides sufficient information to make decisions about service needs;



(10) "Service array" means those services in the system of care that address the varying areas of needs of children with emotional disturbance and their families and shall include but not be limited to:

- (A) Behavioral health services;
- (B) Substance abuse services;
- (C) Social services;
- (D) Education services;
- (E) Health services;
- (F) Vocational services;
- (G) Recreational services;
- (H) Case management;
- (I) Advocacy; and
- (J) Other necessary services;

(11) "Single point of entry" means a unit, agency, or group designated as the gatekeeper for the Child and Adolescent Service System Program service system for children with emotional disturbance and their families;

(12) "Statewide plan" means a comprehensive strategy that identifies the procedures for developing and implementing the system of care that is prepared by the council incorporating all regional plans; and

(13) "System of care" means a comprehensive spectrum of behavioral health and other necessary services organized into a coordinated network to meet the multiple and changing needs of children with emotional disturbance, based on principles set forth in this subchapter.

**History.** Acts 1991, No. 964, § 2; 2001, No. 1517, § 2; 2005, No. 2209, § 1.

### **20-47-505. Child and Adolescent Service System Program Coordinating Council.**

(a)(1) There is created a Child and Adolescent Service System Program Coordinating Council that shall meet on a quarterly basis and at other times deemed necessary to perform its functions.

(2) The coordinating council shall include the following persons to be selected and appointed by the Commissioner of Education and the Director of the Department of Human Services:

- (A) At least three (3) parents, parent surrogates, or family members of a child or children with emotional disturbance;
- (B) A member of an ethnic minority;
- (C) A child advocate;
- (D) Child and Adolescent Service System Program coordinators from each of the certified community mental health centers;

(E)(i) One (1) or more representatives from specific divisions or agencies in the Department of Human Services and the Department of Education.

(ii) Each representative shall have official duties related to the delivery of behavioral health services for children and adolescents with emotional disturbances.

(iii) Specific designations of membership of the coordinating council shall be determined through interdepartmental and intradepartmental agreements that will be renewed on an annual basis; and

(F)(i) At least seven (7) representatives from private or public agencies or organizations that are stakeholders in behavioral health services for children and adolescents with emotional disturbances.

(ii) The commissioner and the director shall jointly appoint an appropriate number of stakeholders.

(b) The coordinating council shall:

(1) Advise and report to the commissioner and the director on matters of policy and programs related to children with emotional disturbance and their families;

(2) Identify and recommend fiscal, policy, training, and program initiatives and revisions based on needs identified in the planning process;

(3) Provide specific guidelines for the development of regional services and plans based on the guiding principles of the system of care;

(4) Review and approve regional plans developed by regional program teams and incorporate the regional plans into the statewide plan;

(5) Ensure that mechanisms for accountability are developed and implemented;

(6) Submit a statewide plan and budget recommendations to the commissioner and the director on or before March 15 of each even-numbered year thereafter preceding the legislative session;

(7) Develop and recommend special projects to the commissioner and the director;

(8) Provide a written report on a quarterly basis to the House Committee on Aging, Children and Youth, Legislative and Military Affairs and the Senate Interim Committee on Children and Youth that summarizes progress implementing this subchapter;

(9) Establish guidelines and procedures for the voting membership, officers, and annual planning of both the coordinating council and the regional program planning teams which the coordinating council will review and update on an annual basis; and

(10) Make recommendations for corrective action plans to the commissioner and the director in the event that a regional program planning team does not produce a timely regional plan that meets a plan of care or fails to implement the approved regional plan.

**History.** Acts 1991, No. 964, § 5; 1997, No. 312, § 16; 2001, No. 1517, § 4; 2005, No. 2209, § 2; 2013, No. 1132, § 31.

**Amendments.** The 2013 amendment substituted “commissioner and the director” for “directors” throughout (b).

## 20-47-506. Regional Child and Adolescent Service System Program Coordinating Council planning teams.

(a) A regional Child and Adolescent Service System Program planning team shall be established in each community mental health center catchment area.



(b)(1) Each team shall include individuals who are not state employees and who are not providers of services to children with emotional disturbance or their families but who are parents, parent surrogates, family members, or consumers.

(2) Every effort shall be made to encourage and assist parents, parent surrogates, family members, consumers, and advocates to participate in program planning teams.

(c) The regional program planning teams shall include agency representatives from the community mental health centers, the Division of Developmental Disabilities Services, the Division of Children and Family Services, the Department of Health, the local school districts or education service cooperatives, and any willing provider.

(d) Additional representatives of other local services and programs shall be added by the regional team and will include representatives from the juvenile justice system or youth services providers and local preschool programs, if possible.

(e) Each regional team member may appoint a single person to serve as his or her proxy.

(f) The regional program planning team shall:

(1) Advise and report to the Child and Adolescent Service System Program Coordinating Council on matters of policies, resources, programs, and services relating to children with emotional disturbance and their families;

(2) Identify and recommend program initiatives and revisions based on area and community-based needs;

(3) Submit a regional plan and guidelines for interagency service delivery teams to the coordinating council on or before February 15 of each even-numbered year preceding the legislative session;

(4) Develop and implement special projects for community-based services; and

(5)(A) Ensure that interagency service teams are established and utilized in coordinating services for children and adolescents referred to the program.

(B) Each service delivery team shall have sufficient and appropriate representation from identified service providers and will complete a multiagency plan of services for each child or adolescent receiving program services.

(C) Each member of the service delivery teams shall share information, evaluations, and data necessary to produce an effective, individualized multiagency plan of services.

(D) Every effort shall be made to assist parents, parent surrogates, family members, and consumers to participate as members of the interagency service delivery team.

**History.** Acts 1991, No. 964, § 6; 2001, No. 1517, § 5; 2005, No. 2209, §§ 3, 4; 2007, No. 617, § 40.



**20-47-507. Child and Adolescent Service System Program Coordinating Council staff.**

(a) The staff for the Child and Adolescent Service System Program Coordinating Council shall be provided by the Child and Adolescent Service System Program project for the first two (2) years and subsequently by the Division of Behavioral Health Services.

(b) The division shall serve as the coordinating agency and shall develop and support the regional program team network and the coordinating council and shall provide training and technical assistance relevant to the system of care.

(c) Annual site reviews and program evaluations of regional program teams will be coordinated by the division and shall involve a multi-agency team of professionals, family members, consumers, and advocates.

(d) The division's program staff shall provide an annual report summarizing program regional and coordinating council activities, strategic plans, and outcomes to the Director of the Department of Human Services and the Commissioner of Education each year on or before October 15.

**History.** Acts 1991, No. 964, § 7; 2001, No. 1517, § 6; 2005, No. 2209, § 5.

**20-47-510. Coordination and oversight — Annual reports.**

(a) The Division of Behavioral Health Services is designated the state agency responsible for the coordination and oversight of the Comprehensive Children's Behavioral Health System of Care Plan.

(b) All state agencies that receive funding, either state or federal, shall participate in collaborative planning for the system of care to support behavioral health services for children and adolescents.

(c) Each state agency that receives funding, either state or federal, to support behavioral health services for children and adolescents shall:

(1)(A) Enter into an interagency collaborative agreement with the division on or before July 2005 with regard to the responsibilities of each agency in the development and implementation of the Comprehensive Children's Behavioral Health System of Care Plan.

(B) The agreements shall be updated annually; and

(2) Submit all pertinent information, including expenditures and programming data, to the division in the time and manner established through the collaborative agreements.

(d)(1) On or before April 15, 2006, for the fiscal year beginning July 1, 2006, and annually thereafter, the division shall submit the state plan for the comprehensive child and adolescent system of care to:

(A) The commissioner and the director; and

(B) The House Committee on Aging, Children and Youth, Legislative and Military Affairs and the Senate Interim Committee on Children and Youth.

(2) The state plan for the Child and Adolescent Service System Program Comprehensive Children’s Behavioral Health System of Care Plan shall include, but not be limited to:

- (A) The projected budget for each state agency that will be used to support behavioral health services;
  - (B) Prevention and early intervention;
  - (C) The service array and capacity for services supported through public funds that are available statewide and county by county; and
  - (D) An assessment of service deficits with recommendations for a plan to address service deficits with available funds.
- (e)(1) On or before October 15, 2006, for the fiscal year beginning July 1, 2005, and annually thereafter, the division shall submit a report concerning the operation of the Comprehensive Children’s Behavioral Health System of Care Plan to:
- (A) The commissioner and the director; and
  - (B) The House Committee on Aging, Children and Youth, Legislative and Military Affairs and the Senate Interim Committee on Children and Youth.
- (2) The report shall include, but not be limited to:
- (A) Actual funds expended for child and adolescent behavioral health services;
  - (B) Prevention and early intervention services;
  - (C) Service utilization data at all levels of care; and
  - (D) Outcome data for the system of care.

**History.** Acts 2005, No. 2209, § 6; deleted “Interim” following “The House” 2013, No. 1132, §§ 32, 33. in (d)(1)(B) and (e)(1)(B).

**Amendments.** The 2013 amendment

**SUBCHAPTER 6 — PROTOCOL, SUBMISSION, AND EVALUATION OF REPORTS —  
MONITORING OF COMPLIANCE**

SECTION.	SECTION.
20-47-601. Definitions.	20-47-603. Conditional effectiveness.
20-47-602. Protocols and accountability.	

**20-47-601. Definitions.**

- As used in this subchapter:
- (1) “Community mental health centers” means those private non-profit organizations certified by the Division of Behavioral Health Services under § 20-47-202 as community mental health centers and contracted to perform designated public mental health services in the respective catchment areas of the state;
  - (2) “Inmate with mental illness” means a jail inmate who, after being assessed by a person qualified by licensure to conduct an assessment, meets the criteria for serious mental illness or is in danger of harm to self or to others;
  - (3) “Jail inmate” means a natural person who is in the custody of law enforcement authorities within the confines of a county jail;



(4) "Persons with mental illness" means a person who appears to be a danger to himself or herself or to others or to need mental health evaluation for treatment and may include an individual detained by a law enforcement officer; and

(5) "Protocol" means standardized outlines of the steps to be taken by law enforcement officers, jails, community mental health centers, or regional secure psychiatric facilities to handle the situation of each person with mental illness arrested by a law enforcement officer.

**History.** Acts 2007, No. 1012, § 1.

### **20-47-602. Protocols and accountability.**

(a) Each county jail shall prepare and may use during the intake process a standard checklist, including behavioral indicators of mental health problems.

(b) If a checklist is used, the checklist shall be a permanent part of the jail inmate's record and shall record all mental health efforts that should be taken in relation to the jail inmate.

(c) Each county jail shall adopt the standard protocols to assist law enforcement personnel and mental health personnel as follows:

(1) A protocol that sets forth the steps that should be taken initially for all arrested persons to determine their mental health status, including physical indications that may affect mental health status;

(2)(A) A protocol to be used for those persons who, based on the results of the protocol drafted under subdivision (c)(1) of this section, may be in need of psychiatric or co-occurring condition treatment.

(B) Under the protocol drafted under subdivision (c)(2)(A) of this section, only licensed mental health professionals shall be responsible for comprehensive screening and assessment subsequent to a finding that the arrested person is in need of psychiatric or co-occurring condition treatment.

(C) Ordinarily the mental health professionals under subdivision (c)(2)(B) of this section should be supplied by the community mental health center for the catchment area in which the jail is located; and

(3)(A) A protocol for case management for jail inmates with a mental illness who are referred to a community mental health center.

(B) The protocol drafted under subdivision (c)(3)(A) of this section shall outline the responsibilities of each party and the steps to be followed in providing treatment to the referred inmate.

(C) The protocol drafted under subdivision (c)(3)(A) of this section shall include a crisis plan for periods beyond the normal work day or work week.

(d)(1) A standard model for the checklist to be prepared under this section and a standard model for the protocols to be drafted under this section shall be prepared by a committee to be convened by the Division of Behavioral Health Services within six (6) months after July 31, 2007.



(2) The committee convened under subdivision (d)(1) of this section shall consist of a representative designated by each of the following agencies or departments:

- (A) Arkansas Association of Chiefs of Police;
- (B) County Judges Association of Arkansas;
- (C) Arkansas Judicial Council;
- (D) Arkansas Municipal League;
- (E) Arkansas Sheriffs' Association;
- (F) Community mental health centers;
- (G) Criminal Justice Institute;
- (H) Department of Community Correction;
- (I) Disability Rights Center;
- (J) Division of Behavioral Health Services;
- (K) Office of the Prosecutor Coordinator;
- (L) Department of Psychiatry of the University of Arkansas for Medical Sciences; and
- (M) Arkansas Public Defender Commission.

(3) The committee shall submit the completed standard protocols and the standard checklist required under subdivision (d)(1) of this section to the division and to the Arkansas Judicial Council for approval.

(4) The division shall provide copies of the standard protocols and the standard checklist to sheriffs, chiefs of police, and county judges and shall post the standard protocols and the standard checklist on a public website.

(e) The committee convened under subdivision (d)(1) of this section shall recommend:

(1) Establishment of the needs for acute mental health beds throughout the state; and

(2) Provision of appropriate funding where needed for construction, operations, renovation, and equipment for meeting the state's needs for acute mental health beds to the extent such funds are appropriated for the purpose.

(f) The division shall develop a standardized report related to all aspects of the implementation of this subchapter.

(g) Each community mental health center shall complete and submit quarterly to the division the report developed under subsection (e) of this section.

(h) The division shall publish annually within sixty (60) days after the end of the state's fiscal year a compilation of the quarterly reports to be made available to the public and, if necessary, to serve as the basis for action to end.

**History.** Acts 2007, No. 1012, § 1; The 2011 amendment inserted "and" following "county judges" in (d)(4).  
2009, No. 952, § 9; 2011, No. 1121, § 12.

**Amendments.** The 2009 amendment substituted "adopt" for "adapt" in (c).

**20-47-603. Conditional effectiveness.**

Unless sufficient appropriations are provided for the purposes of this subchapter, the parties have no new obligations under this subchapter.

**History.** Acts 2007, No. 1012, § 1.

**SUBCHAPTER 7 — ARKANSAS SYSTEM OF CARE FOR BEHAVIORAL HEALTH CARE SERVICES FOR CHILDREN AND YOUTH ACT**

SECTION.	SECTION.
20-47-701. Title.	20-47-705. Behavioral health care initiatives.
20-47-702. Purpose.	20-47-706. Assessment tool.
20-47-703. Findings.	20-47-707. Multiagency plan of services.
20-47-704. Children’s Behavioral Health Care Commission — Composition — Duties.	20-47-708. Annual report.
	20-47-709. Rules.

**20-47-701. Title.**

This subchapter shall be known and may be cited as the “Arkansas System of Care for Behavioral Health Care Services for Children and Youth Act”.

**History.** Acts 2007, No. 1593, § 1.

**20-47-702. Purpose.**

The purpose of this subchapter is to help facilitate the establishment of an improved system of behavioral health care for children and youth, especially those with serious emotional disturbances.

**History.** Acts 2007, No. 1593, § 1.

**20-47-703. Findings.**

The General Assembly finds:

- (1) The system for providing behavioral health care services to children, youth, and their families should ensure that those services are appropriate, cost-effective, and provided in the least restrictive settings;
- (2) Behavioral health and other services identified in § 20-47-502(10) are provided to children and youth by various departments, agencies, and providers at both the state and local level, often without appropriate or effective collaboration;
- (3) Providing effective services for children with the most severe needs requires many areas of expertise and shared responsibility among the aforementioned departments, agencies, and providers; and
- (4) The system of behavioral health care should be built upon the foundation established by the Child and Adolescent Service System Program principles identified in § 20-47-503. The guiding principles for establishing the system of care should be:

(A) The system should be family-driven, child-centered, and youth-guided and should include family participation at all levels of the services system;

(B) The system should be community-based with decision-making responsibility and management at the regional and local levels; and

(C) The system should be culturally competent, with agencies, programs, and services responsive to the cultural and individual differences of the populations they serve.

**History.** Acts 2007, No. 1593, § 1.

#### **20-47-704. Children's Behavioral Health Care Commission — Composition — Duties.**

The Governor shall establish a Children's Behavioral Health Care Commission. The commission shall:

(1) Consist of at least ten (10) but no more than twenty (20) members, who shall:

(A) Include families and advocates for children receiving behavioral health care services and representatives from a variety of behavioral health care agencies, disciplines, and providers; and

(B) Serve three-year terms, except that the initial term for two-thirds (2/3) of the membership shall be equally divided by lot with one-half of such persons serving an initial term of one (1) year and the other half serving an initial term of two (2) years; and

(2) Provide advice and guidance to the Department of Human Services and other state agencies providing behavioral health care services to children, youth, and their families on the most effective methods for establishing a system of care approach.

**History.** Acts 2007, No. 1593, § 1.

#### **20-47-705. Behavioral health care initiatives.**

The Department of Human Services, with advice from the Children's Behavioral Health Care Commission, shall:

(1) Identify and implement actions for ensuring that children, youth, and their families are full partners in design and implementation of all aspects of the system of care as well as full partners in decisions about their care or their child's care;

(2) Identify up to two million dollars (\$2,000,000) per year to apply to the following purposes:

(A) Meeting extraordinary, non-Medicaid reimbursable needs of children, youth, and their families, as identified in multi-agency plans of services;

(B) Supporting creation or strengthening of entities designed to guide the development and operation of local, regional, and state components of the system of care;

(C) Strengthening family and advocate skills and capacity to provide meaningful input on the system of care; and



(D) Supporting the development and enhancement of needed behavioral health care services in underserved areas;

(3) Revise Medicaid rules and regulations to increase quality, accountability, and appropriateness of Medicaid-reimbursed behavioral health care services, including, but not limited to:

(A) Clarifying behavioral health care services definitions to assure that the definitions are appropriate to the needs of children, youth, and their families;

(B) Revising the process for Medicaid to receive, review, and act upon requests for behavioral health care for children and youth classified as seriously emotionally disturbed;

(C) Clarifying Medicaid certification rules for providers serving children, youth, and their families to assure that the certification rules correlate with the requirements for enrollment as a Medicaid provider of behavioral health care services;

(D) Defining a standardized screening and assessment process designed to provide early identification of conditions that require behavioral health care services. The standardized process shall ensure that:

(i) Assessments guide service decisions and outcomes and, if appropriate, development of a multi-agency plan of services; and

(ii) Services delivered are appropriate to meet the needs of the child as identified by the assessment;

(4) Research, identify, and implement innovative and promising local, regional, or statewide approaches for better managing the state's resources devoted to children's behavioral health; and

(5) Create additional capacity within the Division of Behavioral Health Services to develop, support, and oversee the new system of care for behavioral health services for children, including:

(A) Developing an outcomes-based data system to support an improved system of tracking, accountability, and decision-making; and

(B) Creating additional staff support to provide technical assistance, utilize information, identify and encourage best practices, monitor performance, and recommend system improvements.

**History.** Acts 2007, No. 1593, § 1.

#### **20-47-706. Assessment tool.**

The standardized screening and assessment tool established by Medicaid rules shall:

(1) Guide service decisions and outcomes; and

(2) Establish guidelines to identify children who need a multi-agency plan of services.

**History.** Acts 2007, No. 1593, § 1.

**20-47-707. Multiagency plan of services.**

Each multiagency plan of services shall:

- (1) Be consistent with the results of the standardized screening and assessment established by Medicaid rules;
- (2) Provide for collaboration among the child, the persons or entities responsible for the child’s care and custody, and the providers of behavioral health care services for the child; and
- (3) Be appropriate to meet the behavioral health care needs of the child as defined by the assessment.

**History.** Acts 2007, No. 1593, § 1.

**20-47-708. Annual report.**

The Department of Human Services shall report annually on progress to the:

- (1) Governor;
- (2) House Committee on Aging, Children and Youth, Legislative and Military Affairs and the Senate Interim Committee on Children and Youth; and
- (3) House Committee on Public Health, Welfare, and Labor and the Senate Committee on Public Health, Welfare, and Labor.

**History.** Acts 2007, No. 1593, § 1; deleted “Interim” following “House” in (2) 2013, No. 1132, § 34. and twice following “House” and “Senate”  
**Amendments.** The 2013 amendment in (3).

**20-47-709. Rules.**

The Department of Human Services shall promulgate rules in accordance with the Arkansas Administrative Procedure Act, § 25-15-201 et seq., as necessary to carry out this subchapter.

**History.** Acts 2007, No. 1593, § 1.

**CHAPTER 48**

**TREATMENT OF THE DEVELOPMENTALLY DISABLED**

SUBCHAPTER.

- 1. GENERAL PROVISIONS.
- 4. HUMAN DEVELOPMENT CENTERS GENERALLY.
- 6. LOCATION ACT FOR COMMUNITY HOMES FOR DEVELOPMENTALLY DISABLED PERSONS.
- 7. RELATIONSHIP BETWEEN STATE AND COMMUNITIES TO PROVIDE FOR COMMUNITY-BASED SERVICES.
- 8. CRIMINAL RECORDS CHECKS FOR EMPLOYEES OF PROVIDERS OF CARE TO DISABLED ADULTS. [REPEALED.]
- 9. INTERMEDIATE CARE FACILITIES.
- 10. ALTERNATIVE COMMUNITY SERVICES WAIVER PROVIDER FEE.
- 11. MANAGED EXPANSION FOR CHILD HEALTH MANAGEMENT SERVICES.

## SUBCHAPTER 1 — GENERAL PROVISIONS

## SECTION.

20-48-101. Definitions.

20-48-102. [Repealed.]

20-48-103. Purpose — Use of certain funds.

## SECTION.

20-48-105. Nonprofit community programs — Expansion of services.

**Effective Dates.** Acts 2013, No. 1017, § 3[4]: July 1, 2013. Emergency clause provided: "It is found and determined by the General Assembly of the State of Arkansas that managed expansion of the child health management services program and the developmental day treatment clinic services for children program is in the best interest of children served and critical to economic efficiencies necessary to sustain the Medicaid program; that managed expansion is also necessary

to ensure adequate geographic coverage in rural areas; and that the managed expansion rules in place for developmental day treatment clinic services have worked well and should serve as the model for child health management services or any successor program. Therefore, an emergency is hereby declared to exist and this act being necessary for the immediate preservation of the public peace, health and safety shall become effective on July 1, 2013.

**20-48-101. Definitions.**

As used in this chapter:

(1)(A) "Accredited nonprofit entity" means a nonprofit entity that:

- (i) Has successfully completed an ongoing accreditation process that is related to the delivery of services to adults with developmental disabilities and is offered by a national accrediting organization;
- (ii) Satisfies the appropriate licensure criteria established by the Division of Developmental Disabilities Services of the Department of Human Services; and
- (iii) Is positioned to provide nonresidential services to adults with developmental disabilities upon licensure by the division when no existing nonprofit community program is interested in providing the specific category of nonresidential services to adults with developmental disabilities that have been identified by the division as underserved.

(B) As used in subdivision (1)(A)(i) of this section, "national accrediting organization" includes without limitation:

- (i) The Commission on Accreditation of Rehabilitation Facilities; or
- (ii) Any other similar national accrediting organization recognized by the division;

(2) "Developmental disability" means a disability of a person that:

- (A)(i) Is attributable to mental retardation, cerebral palsy, spina bifida, Down syndrome, epilepsy, or autism;
- (ii) Is attributable to any other condition of a person found to be closely related to mental retardation because the condition results in



an impairment of general intellectual functioning or adaptive behavior similar to that of a person with mental retardation or requires treatment and services similar to that required for a person with mental retardation; or

(iii) Is attributable to dyslexia resulting from a disability described in subdivision (2)(A)(i) of this section or subdivision (2)(A)(ii) of this section;

(B) Originates before the person attains the age of twenty-two (22) years;

(C) Has continued or can be expected to continue indefinitely; and

(D) Constitutes a substantial handicap to the person's ability to function without appropriate support services, including, but not limited to, planned recreational activities, medical services such as physical therapy and speech therapy, and possibilities for sheltered employment or job training;

(3) "Existing operations" means the provision by a qualified non-profit community provider of one (1) or more of the following services without regard to order:

(A) A developmental day treatment clinic services preschool program or adult development program;

(B) A licensed developmental disability services group home in operation and recognized by the division on or before July 1, 1995;

(C) An intermediate care facility for the mentally retarded program with fifteen (15) beds or less; or

(D) An apartment complex in operation and serving individuals with developmental disabilities on or before January 1, 2008;

(4) "Human development center" means an institution maintained for the care and training of persons with developmental disabilities;

(5)(A) "Nonprofit community program" means a program that provides nonresidential services to persons with developmental disabilities or nonresidential and residential services to persons with developmental disabilities and is licensed by the division.

(B) A nonprofit community program serves as a quasi-governmental instrumentality of the state by providing support and services to persons who have a developmental disability or delay and would otherwise require support and services through state-operated programs and facilities; and

(6)(A) "Qualified nonprofit community program" means a nonprofit community program that holds a valid nonprofit community program license issued by the division.

(B) "Qualified nonprofit community program" includes:

(i) A nonprofit community program that holds a license that was issued by the division on or before February 1, 2007; and

(ii) An accredited nonprofit entity that is awarded a license as a nonprofit community program by the division after February 1, 2007.

**Amendments.** The 2011 amendment inserted “spina bifida, Down syndrome” in (2)(A)(i). and in (1)(A)(iii), substituted “when” for “because” and “program” for “provider.”

The 2013 amendment substituted “adults” for “persons” throughout (1)(A)

### **20-48-102. [Repealed.]**

**Publisher’s Notes.** This section, concerning the prohibition of abuse, ridicule, and teasing, was repealed by Acts 2005, No. 1994, § 528. The section was derived from Acts 1971, No. 433, ch. 7, § 2; A.S.A. 1947, § 59-602.

### **20-48-103. Purpose — Use of certain funds.**

It is the specific recommendation of the General Assembly that the Division of Developmental Disabilities Services of the Department of Human Services utilize Title XIX, social services block grant, and state grants-in-aid funds available to nonprofit community programs to seek to achieve the following goals:

(1) Providing for operation of nonprofit community programs that the state agency encouraged the nonprofit community programs to build with nonstate funds;

(2) Determination by the division of reasonable costs for the services provided by nonprofit community programs; and

(3) That the state not reduce reasonable cost funding of nonprofit community programs.

**History.** Acts 1985, No. 777, § 18; 1989 (1st Ex. Sess.), No. 246, § 16; 2007, No. 645, § 2.

### **20-48-105. Nonprofit community programs — Expansion of services.**

(a)(1) The intent of this section is to avoid unnecessary duplication of costs and services in the expansion of nonresidential services to adults with developmental disabilities.

(2) A designation by the Division of Developmental Disabilities Services of the Department of Human Services that a county is underserved with regard to a specific category of nonresidential services to adults with developmental disabilities establishes that an expansion of nonresidential services to adults with developmental disabilities in the underserved county is necessary.

(b)(1) The division shall not issue a new license for operation of a nonprofit community program or approve an application from a nonprofit community program to implement additional nonresidential services to benefit adults with developmental disabilities that are not currently offered by the nonprofit community program unless the division has determined that:

(A) The county in which the program seeks to operate is underserved with regard to a specific category of nonresidential services



currently offered to adults with developmental disabilities and currently funded from available state or federal funds; or

(B)(i) The county in which the program seeks to operate is underserved with regard to new services not currently available to adults with developmental disabilities and the new services should be made available to benefit adults with developmental disabilities.

(ii) State or federal funds are available in amounts necessary to support the delivery of new services not currently available to adults with developmental disabilities.

(2)(A) The division shall provide written notice by certified mail of its designation under subdivision (b)(1) of this section to all nonprofit community programs with existing operations in the county designated by the division as underserved.

(B) If nonprofit community programs with existing operations in the county that do not currently offer the specific category of nonresidential services identified by the division as underserved determine not to expand the identified nonresidential service to adults with developmental disabilities in the underserved county, the division shall provide written notice by certified mail of its designation under subdivision (b)(1) of this section to all nonprofit community programs in the remainder of the state.

(C) If all nonprofit community programs in the remainder of the state determine not to expand the identified nonresidential service to adults with developmental disabilities in the underserved county, the division shall provide notice to the general public in a newspaper of statewide general circulation.

(c) In granting an approval under this section, the division shall give approval in the following order of preference:

(1) A qualified nonprofit community program with existing operations in the county that does not currently offer the specific category of nonresidential services to adults with developmental disabilities identified by the division as underserved;

(2) A qualified nonprofit community program from another county in the state;

(3) An accredited nonprofit entity in the underserved county;

(4) An accredited nonprofit entity from another county in the state; and

(5) An accredited nonprofit entity from outside the state.

(d)(1)(A) A license from the division is required for operation of a nonprofit community program.

(B) A qualified nonprofit community program is required to apply to and obtain the approval of the division to implement additional nonresidential services to adults with developmental disabilities that are not currently offered by the qualified nonprofit community program.

(2)(A) If an application is approved, the division shall issue a new license or service expansion approval if it finds that the proposed nonresidential service expansion meets the criteria for approval established by the division.



(B) If the application is denied, the division shall send written notice of the denial to the applicant that sets forth the criteria that the proposed nonresidential service expansion failed to meet.

**History.** Acts 1997, No. 1360, § 123; 2007, No. 645, § 3; 2013, No. 1017, § 3.

**A.C.R.C. Notes.** Acts 2013, No. 1371, § 13, provided: "GRANTS IN AID — CONDITIONS FOR RECEIVING FUNDS. Private non-profit community-based programs licensed by the Department of Human Services, Developmental Disabilities Services, are eligible to receive funds appropriated for Grants to Community Providers in the Developmental Disabilities Services — Grants-in-Aid appropriation of this Act, and as a condition of receiving such funds they shall:

"1. Meet minimum standards of performance in the delivery of services to people with disabilities as defined by the Department of Human Services, Developmental Disabilities Services.

"2. Supply statistical and financial data to the Department of Human Services, Developmental Disabilities Services.

"3. Establish and maintain a sound financial management system in accor-

dance with guidelines as set forth by the Department of Human Services.

"4. Establish and maintain community support programs designed to provide coordinated care and treatment to ensure ongoing involvement and individualized services for persons with disabilities. Every community support program shall provide services for persons with disabilities who reside within the respective area of the program.

"The provisions of this section shall be in effect only from July 1, 2013 through June 30, 2014."

**Amendments.** The 2013 amendment substituted "Expansion" for "Extension or expansion" in the section heading; substituted "adults" for "persons" and deleted "extension or" preceding "expansion" throughout; in (b)(1), substituted "The county in which the program seeks to operate" for "A county of the state" twice, and added "benefit" before "adults" twice.

## SUBCHAPTER 2 — ARKANSAS MENTAL RETARDATION ACT

### 20-48-207. Board of Developmental Disabilities Services — Contracts for provision of services.

**Publisher's Notes.** This Publisher's Note is being set out to correct a prior omission.

Acts 1985, No. 348, § 3, provided, in part, that all functions vested in the Board of Developmental Disabilities Services with respect to community programs, workshops, and other services for the mentally retarded or developmentally disabled, and all other duties, programs, or services under the board's jurisdiction,

except those specified in subsection (a) of this section, were transferred to the Department of Human Services to be performed by the divisions, offices, etc., designated by the director of the department. The section specifically transferred to the department the powers and duties granted the board under §§ 20-48-207 — 20-48-209, 20-48-211, and 20-48-301 — 20-48-305.

## SUBCHAPTER 4 — HUMAN DEVELOPMENT CENTERS GENERALLY

### SECTION.

20-48-406. Admission procedures.

20-48-415. Board of Developmental Disabilities Services — Pow-

ers and duties — Proceedings — Appointment of superintendents.

**A.C.R.C. Notes.** Acts 2013, No. 1371, § 12, provided: "DEVELOPMENTAL DISABILITIES — VOCATIONAL TRAINEES. The Division of Developmental Disabilities Services of the Department of Human Services is hereby authorized to provide employment opportunities for people with developmental disabilities residing at the Human Development Centers who work less than a competitive employment level.

"The provisions of this section shall be in effect only from July 1, 2013 through June 30, 2014."

Acts 2013, No. 1371, § 15, provided: "HUMAN DEVELOPMENT CENTERS AND COMMUNITY PROVIDERS

"(A) The Developmental Disabilities Services Board or the Department of Human Services shall not close any of the state administered Human Development Centers which are located at Conway, Arkadelphia, Jonesboro, Booneville, and Warren.

"(B) The Department of Human Services shall continue to accept clients for whom it has determined that therapy and residential services are needed at state administered Human Development Centers and Community Programs licensed by DDS shall continue to accept clients for whom it has been determined in accordance with federal law that are in need of services in the community.

"(C) Except for use as federal matching funds, no funds for community based services licensed by DDS shall be transferred from Grants to Community Providers line item of the Developmental Disabilities Services — Grants-in-Aid appropriation

unless the transfer(s) directly benefit(s) community based services for persons with developmental disabilities or from the appropriation for the Human Development Centers unless the transfer(s) directly benefit(s) the Human Development Centers.

"(D) Nor shall any general revenue funding as of July 1, 2013 from the Grants to Community Providers line item of the Developmental Disabilities Services — Grants-in-Aid appropriation for persons with developmental disabilities or from any other general revenues as of July 1, 2013, applied as federal matching funds for community based services licensed by DDS on July 1, 2013 be reduced below the approved funding level on July 1, 2013; nor shall the general revenues applied as federal matching funds for the Human Development Centers be reduced below the approved funding level on July 1, 2013."

**Effective Dates.** Acts 2003, No. 1473, § 74: July 1, 2003. Emergency clause provided: "It is found and determined by the General Assembly of the State of Arkansas that this act includes technical corrects to Act 923 of 2003 which establishes the classification and compensation levels of state employees covered by the provisions of the Uniform Classification and Compensation Act; that Act 923 of 2003 will become effective on July 1, 2003; and that to avoid confusion this act must also effective on July 1, 2003. Therefore, an emergency is declared to exist and this act being necessary for the preservation of the public peace, health, and safety shall become effective on July 1, 2003."

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## 20-48-406. Admission procedures.

(a)(1) Upon receipt of the petition, the Board of Developmental Disabilities Services shall make a determination as to whether or not a human development center then has adequate facilities and funds to properly care for, treat, and train the individual. If the board determines that no center currently has adequate facilities and funds, then the individual shall not be admitted to a center. If the board determines that the centers do have adequate facilities and funds to care for, treat, and train the individual and that the proposed admission would not crowd the centers beyond their maximum capacity, it shall cause an investigation to be made on the petition.



(2)(A) The investigation shall include an examination of the individual by two (2) reputable physicians appointed or designated by the board for the purpose of determining the mental status and condition of the individual and whether or not he or she has or is a carrier of a contagious or infectious disease.

(B) The investigation may also include one (1) or more examinations of the individual by psychologists, psychiatrists, and physicians designated by the board.

(C) The board may proceed toward admission of the individual to the center in accordance with the provisions of subsection (b) or (c) of this section, whichever the board may deem proper in the particular case, but taking into consideration the request contained in the petition if the board determines from the investigation that:

- (i) The statements made in the petition are true and correct;
- (ii) The individual is eligible under the provisions of § 20-48-404;
- (iii) The individual neither has nor is a carrier of a contagious or infectious disease; and
- (iv) The individual is not suffering from psychosis of such nature and extent that a center could not properly and beneficially care for, treat, and train the individual with the facilities and program it then has.

(b) The board may permit the voluntary admission of the individual to a center for such period of time as the board may deem necessary for the proper care, training, and education of the individual. The admission shall be by action of the board without the necessity of any court procedure.

(c)(1) The board may determine that the individual should be admitted to a center by legal commitment only. In that event, the board shall file the petition for admission with the probate court of the county in which the individual resides. There shall be filed with the court, along with the petition, such of the reports received by the board in the course of its investigation and examination as the board may deem necessary.

(2) The court shall promptly set a time and place for a hearing on the petition.

(3) The court may appoint one (1) or two (2) reputable physicians to examine the individual and report to the court the mental status of the individual and whether he or she is afflicted with or a carrier of a contagious or infectious disease, or it may adopt the report of the physician appointed by the board in the investigation of the individual as provided for in subsection (a) of this section.

(4) Upon the hearing on the petition, the court shall determine whether or not the individual should be committed to a center for care, treatment, and training and shall enter an appropriate order in accordance with its determination.

**History.** Acts 1955, No. 6, § 5; 1957, No. 349, § 2; A.S.A. 1947, § 59-1105; Acts 1997, No. 208, § 22; 2003, No. 1473, § 42.



**20-48-415. Board of Developmental Disabilities Services — Powers and duties — Proceedings — Appointment of superintendents.**

(a) The government and control of the human development centers shall be vested in the Board of Developmental Disabilities Services.

(b) The board:

(1) Shall have charge of the property of the state which may be used for the purposes of the centers;

(2) Shall make and execute its bylaws;

(3) Shall appoint and remove its officers, attendants, and employees and fix their compensation;

(4) Shall exercise a strict supervision of the centers' expenditures; and

(5)(A) May acquire real and personal property by purchase, gift, or other transfer, and may own, sell, and transfer real and personal property and establish trusts.

(B)(i) Ownership of real and personal property under the control of the board shall be in the name of the State of Arkansas, or in the trust or trusts as the board may from time to time create.

(ii) All property under the control of the board, whether owned by the State of Arkansas or in a trust established by the board, shall be held for the benefit of persons with developmental disabilities.

(c)(1) The board shall appoint superintendents who shall not be one (1) of its number. The superintendents shall be reputable, trained administrators of institutions engaged in the care, custody, treatment, and training of children and youth, with at least five (5) years' experience as the superintendent or administrative assistant of such an institution.

(2) The board shall fix the superintendents' salaries and prescribe their duties.

(d)(1) The board shall annually elect from its membership a chair and vice chair, each of whom shall hold office until his or her successor is chosen.

(2) The chair shall preside at meetings of the board, and in his or her absence, the vice chair shall preside.

(3) A superintendent shall serve as executive secretary to the board and shall maintain an official set of minutes of all votes and actions of the board. These minutes shall be signed by the superintendent as executive secretary and by the chair of the board.

(4) The board is authorized to designate the superintendent, or some other competent employee or official of the center, to serve as disbursing officer of all funds of the center.

(e) The board shall meet at least one (1) time each three (3) months and at such other times as the chair may deem advisable.

(f) The superintendent of each center shall annually, or more often if required, present to the board for himself or herself and his or her staff a written report of the management of the center setting forth in detail

all receipts and disbursements and general conditions of the affairs of the center.

(g) The board shall report biennially to the Governor and General Assembly, accompanying its report with the annual report of the superintendent.

(h) A majority vote of the entire membership of the board shall be necessary to take any board action.

(i) The board may make such rules and regulations respecting the care, custody, training, and discipline of individuals admitted to the centers and the management thereof and of its affairs as it may deem for the best interest of the centers and the State of Arkansas.

**History.** Acts 1955, No. 6, §§ 13, 14; A.S.A. 1947, §§ 59-1113, 59-1114; Acts 2005, No. 662, §§ 1, 2.

## **SUBCHAPTER 5 — HUMAN DEVELOPMENT CENTERS — PROPERTY AND FINANCES**

### **20-48-511. Developmental disabilities — Timber sales proceeds — Capital improvements and equipment.**

**A.C.R.C. Notes.** Acts 2013, No. 1371, § 14, provided: “DEVELOPMENTAL DISABILITIES — TIMBER SALES PROCEEDS — CAPITAL IMPROVEMENTS AND EQUIPMENT. The Division of Developmental Disabilities Services is authorized to use the administrative operating accounts for capital improvements to physical plants and for the purchase of capital equipment. The funds shall be held by the Department of Human Services, Division of Developmental Disabilities Services from the proceeds of the sale of timber that may be harvested from land owned by the Division of Developmental Disabilities Services. All funds deposited and all expenses shall be tracked separately. The harvesting of timber is specifically authorized to provide funds to finance capital improvements to the physical plants and for the purchase of major capital equipment.

“The Division of Developmental Disabilities Services shall report all income derived from timber management to the Chief Fiscal Officer of the State and the Arkansas Legislative Council. Any contracts initiated for the harvesting of timber shall be submitted to the Review Subcommittee of the Arkansas Legislative Council for prior review. All expenditures of funds derived from the sale of timber

will be expended in accordance with relevant state purchasing laws.

“The provisions of this section shall be in effect only from July 1, 2013 through June 30, 2014.”

Acts 2013, No. 1396, § 12, provided: “YOUTH SERVICES — TIMBER SALES PROCEEDS — CAPITAL IMPROVEMENTS AND EQUIPMENT. The Division of Youth Services is authorized to use the administrative operating account for capital improvements to the physical plant and for the purchase of capital equipment by the Mansfield Youth Services Facility operated by the Department of Human Services, Division of Youth Services. The funds shall be held by the Department of Human Services, Division of Youth Services from the proceeds of the sale of timber that may be harvested from land owned by the Division of Youth Services. All funds deposited and all expenses shall be tracked separately. The harvesting of timber is specifically authorized to provide funds to finance capital improvements to the physical plant and for the purchase of major capital equipment by the Mansfield Facility from which the timber is sold.

“The Division of Youth Services shall report all income derived from the sale of timber to the Chief Fiscal Officer of the



State and the Arkansas Legislative Council. Any contracts initiated for the harvesting and sale of timber shall be submitted to the Review Subcommittee of the Arkansas Legislative Council for prior review. All expenditures of funds derived from the

sale of timber will be expended in accordance with relevant state purchasing laws.

"The provisions of this section shall be in effect only from July 1, 2013 through June 30, 2014."

## **SUBCHAPTER 6 — LOCATION ACT FOR COMMUNITY HOMES FOR DEVELOPMENTALLY DISABLED PERSONS**

### **SECTION.**

20-48-603. Definitions.

### **20-48-603. Definitions.**

As used in this subchapter, unless the context otherwise requires:

(1)(A) "Developmental disability" means a disability of a person that:

(i) Is attributable to mental retardation, cerebral palsy, spina bifida, Down syndrome, epilepsy, or autism;

(ii) Is attributable to any other condition of a person found to be closely related to mental retardation because it results in impairment of general intellectual functioning or adaptive behavior similar to that of mentally retarded persons or requires treatment and services similar to those required for the persons;

(iii) Is attributable to dyslexia resulting from mental retardation, cerebral palsy, epilepsy, or autism; and

(iv) Has continued or can be expected to continue indefinitely.

(B) "Developmental disability" does not refer to other forms of mental disease or defect not defined in this section;

(2) "Developmentally disabled person" means a person with a developmental disability as defined in this section;

(3) "Division" means the Division of Developmental Disabilities Services of the Department of Human Services or the staff of the division where the context so indicates;

(4)(A) "Family Home I" means a community-based residential home licensed by the division that provides room and board, personal care, habilitation services, and supervision in a single-family environment for not more than eight (8) developmentally disabled persons.

(B) "Family Home II" means a community-based residential home licensed by the division that provides room and board, personal care, habilitation services, and supervision in a multifamily environment for more than eight (8) but fewer than sixteen (16) developmentally disabled persons;

(5) "Permitted use" means a use by right that is authorized in residential zoning districts; and

(6) "Political subdivision" means a county or municipal corporation and includes any boards, commissions, or councils governing land use on behalf of the political subdivision.



**History.** Acts 1987, No. 611, § 3; 2011, No. 68, § 3; 2013, No. 1132, § 35.

**Amendments.** The 2011 amendment inserted “spina bifida, Down syndrome” in (1)(A)(i).

The 2013 amendment substituted “Developmental” for “Development” in (1)(B).

## **SUBCHAPTER 7 — RELATIONSHIP BETWEEN STATE AND COMMUNITIES TO PROVIDE FOR COMMUNITY-BASED SERVICES**

### **SECTION.**

20-48-701. Finding.

20-48-705. Membership of nonprofit organizations.

### **20-48-701. Finding.**

The General Assembly finds that the State of Arkansas contracts with nonprofit community programs serving individuals with developmental disabilities as quasi-governmental instrumentalities of the state in order to provide a service that the state would otherwise provide for this population through state-operated programs and facilities.

**History.** Acts 2001, No. 1792, § 1; 2007, No. 645, § 2 [4].

### **20-48-705. Membership of nonprofit organizations.**

A nonprofit organization licensed or certified by the Division of Developmental Disabilities Services of the Department of Human Services to serve adults shall include an individual with developmental disabilities as an ex officio member of the nonprofit organization’s board of directors or other governing body.

**History.** Acts 2009, No. 1488, § 1.

## **SUBCHAPTER 8 — CRIMINAL RECORDS CHECKS FOR EMPLOYEES OF PROVIDERS OF CARE TO DISABLED ADULTS**

### **SECTION.**

20-48-801 — 20-48-811. [Repealed.]

20-48-812. Criminal history records checks required.

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**Effective Dates.** Acts 2009, No. 762, § 12, provided: “This act shall be effective September 1, 2009.”

**20-48-801 — 20-48-811. [Repealed.]**

**Publisher's Notes.** This subchapter was repealed by Acts 2009, No. 762, § 7. The subchapter was derived from the following sources:

20-48-801. Acts 2001, No. 1548, § 1.  
 20-48-802. Acts 2001, No. 1548, § 1.  
 20-48-803. Acts 2001, No. 1548, § 1.  
 20-48-804. Acts 2001, No. 1548, § 1;  
 2003, No. 1087, § 20; 2003, No. 1381, § 1;  
 2005, No. 968, § 1; 2005, No. 1923, § 7;  
 2007, No. 827, § 169.

20-48-805. Acts 2001, No. 1548, § 1.  
 20-48-806. Acts 2001, No. 1548, § 1.  
 20-48-807. Acts 2001, No. 1548, § 1.  
 20-48-808. Acts 2001, No. 1548, § 1.  
 20-48-809. Acts 2001, No. 1548, § 1.  
 20-48-810. Acts 2001, No. 1548, § 1.  
 20-48-811. Acts 2001, No. 1548, § 1.

**Effective Dates.** Acts 2009, No. 762, § 12, provided: "This act shall be effective September 1, 2009."

**20-48-812. Criminal history records checks required.**

(a) As used in this section:

(1) "Registry records check" means the review of one (1) or more database systems maintained by a state agency that contain information relative to a person's suitability for licensure or certification as a service provider or employment with a service provider to provide care as defined in § 20-38-101; and

(2) "Service provider" means any of the following:

(A) An Alternative Community Services Waiver Program provider certified by the Division of Developmental Disabilities Services of the Department of Human Services;

(B) An early intervention program provider certified by the division; or

(C) A nonprofit community program as defined by § 20-48-101.

(b) Beginning September 1, 2009, a service provider is subject to the requirements of this section and § 20-38-101 et seq., concerning criminal history records checks.

(c)(1) A person offered employment with a service provider on or after September 1, 2009, is subject to the requirements of this section and § 20-38-101 et seq., concerning criminal history records checks.

(2)(A) A person who was offered employment by a service provider prior to September 1, 2009, was subject to a criminal history records check under §§ 20-48-801 — 20-48-811 [repealed] and has continued to be employed by the service provider who initiated the criminal history records check may continue employment with the service provider based on the results of the criminal history records check process conducted under §§ 20-48-801 — 20-48-811 [repealed].

(B) When the person next undergoes a periodic criminal history records check, the person's continued employment with the service provider is contingent on the results of a criminal history records check under § 20-38-101 et seq.

(d)(1) The person who signs an application for licensure or certification as a service provider on or after September 1, 2009, is subject to the requirements of this section and § 20-38-101 et seq., concerning criminal records checks.

(2)(A) The person who signed an application for licensure or certification of a service provider prior to September 1, 2009, was subject to a criminal history records check under §§ 20-48-801 — 20-48-811 [repealed], and has continued to maintain the licensure or certification of the service provider may continue to maintain the licensure or certification of the service provider based on the results of the criminal history records check process conducted under §§ 20-48-801 — 20-48-811 [repealed].

(B) When the service provider next undergoes a periodic criminal history records check, the service provider’s continued licensure or certification is contingent on the results of a criminal history records check under § 20-38-101 et seq.

(e) The division shall establish by rule requirements for registry records checks for:

- (1) An applicant for licensure or certification of a service provider;
  - (2) An applicant for employment with a service provider; and
  - (3) An employee of a service provider.
- (f) The division shall establish by rule:

(1) Requirements for criminal history and registry records checks of persons who volunteer for a service provider; and

(2) The consequences of a determination that a person who proposes to reside in an alternative living home in which services are provided to an individual with developmental disabilities is disqualified from the residency based on the criminal history of the person.

**History.** Acts 2009, No. 762, § 8.

§ 12, provided: “This act shall be effective

**Effective Dates.** Acts 2009, No. 762,

September 1, 2009.”

## SUBCHAPTER 9 — INTERMEDIATE CARE FACILITIES

### SECTION.

20-48-901. Definitions.

20-48-902. Calculation of provider fee.

### SECTION.

20-48-903. Administration.

20-48-904. Use of funds.

### 20-48-901. Definitions.

As used in this subchapter:

(1)(A) “Gross receipts” means all compensation paid to intermediate care facilities for individuals with developmental disabilities for services provided to residents, including without limitation client participation.

(B) “Gross receipts” does not include charitable contributions;

(2)(A) “Intermediate care facility for individuals with developmental disabilities” means a residential institution maintained for the care and training of persons with developmental disabilities, including without limitation mental retardation.

(B) “Intermediate care facility for individuals with developmental disabilities” has the same meaning as “intermediate care facility for the mentally retarded” or “ICF/MR” under federal law.



(C) "Intermediate care facility for individuals with developmental disabilities" does not include:

- (i) Offices of private physicians and surgeons;
- (ii) Residential care facilities;
- (iii) Assisted living facilities;
- (iv) Hospitals;
- (v) Institutions operated by the federal government;
- (vi) Life care facilities;
- (vii) Nursing facilities; or

(viii) A facility which is conducted by and for those who rely exclusively upon treatment by prayer for healing in accordance with tenets or practices of a recognized religious denomination; and

(3) "Medicaid" means the medical assistance program established by Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq., as it existed on January 1, 2009, and administered by the Division of Medical Services of the Department of Human Services.

**History.** Acts 2009, No. 433, § 1.

### **20-48-902. Calculation of provider fee.**

(a)(1) There is levied a provider fee on intermediate care facilities for individuals with developmental disabilities to be calculated in accordance with this section.

(2)(A) The provider fee shall be an amount calculated by the Division of Medical Services of the Department of Human Services to produce an aggregate provider fee payment equal to six percent (6%) of the aggregate gross receipts of all intermediate care facilities for individuals with developmental disabilities.

(B) Aggregate provider fees shall not equal or exceed an amount measured on a state fiscal year basis that may cause a reduction in federal financial participation in Medicaid.

(b)(1)(A) The provider fee of an intermediate facility for individuals with developmental disabilities shall be payable in monthly payments.

(B) Each monthly payment shall be due and payable for the previous month by the thirtieth day of each month.

(2) The division shall seek approval from the Centers for Medicare & Medicaid Services to treat the provider fee of an intermediate care facility for individuals with developmental disabilities as an allowable cost for Medicaid reimbursement purposes.

(c) No intermediate care facility for individuals with developmental disabilities shall be guaranteed, expressly or otherwise, that any additional moneys paid to the intermediate care facility for individuals with developmental disabilities will equal or exceed the amount of its provider fee.

(d)(1) The division shall ensure that the rate of assessment of the provider fee established in this section maximizes federal funding to the fullest extent possible.

(2) If the division determines that the rate of assessment of the provider fee established in this section equals or exceeds the maximum rate of assessment that federal law allows without reduction in federal financial participation in Medicaid, the division shall lower the rate of assessment of the provider fee to a rate that maximizes federal funding to the fullest extent possible.

**History.** Acts 2009, No. 433, § 1.

### **20-48-903. Administration.**

(a) The Director of the Division of Medical Services of the Department of Human Services shall administer this subchapter and shall be subject to the Arkansas Administrative Procedure Act, § 25-15-201 et seq.

(b)(1) In accordance with the Arkansas Administrative Procedure Act, § 25-15-201 et seq., the Division of Medical Services of the Department of Human Services shall promulgate rules and prescribe forms for:

(A) The proper imposition and collection of the provider fee;

(B)(i) The enforcement of this subchapter, including without limitation license or certification nonrenewal, letters of caution, sanctions, or fines.

(ii)(a) The fine for failure to comply with payment and reporting requirements shall be at least one thousand dollars (\$1,000) but no more than one thousand five hundred dollars (\$1,500).

(b) The fine and, if applicable, the outstanding balance of the provider fee shall accrue interest at the maximum rate permitted by law from the date the fine and, if applicable, the provider fee is due until payment of the outstanding balance of the fine and, if applicable, the provider fee;

(C) The format for reporting gross receipts; and

(D) The administration of this subchapter.

(2) The rules shall not grant any exceptions to or exceptions from the provider fee.

**History.** Acts 2009, No. 433, § 1.

### **20-48-904. Use of funds.**

(a)(1) The provider fee assessed and collected under this subchapter shall be deposited into a designated account within the Arkansas Medicaid Program Trust Fund.

(2) The designated account shall be separate and distinct from the general fund and shall be supplementary to the trust fund.

(3) The designated account moneys in the trust fund and the matching federal financial participation under Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq., as it existed on January 1, 2009, shall be used only for:

(A) Continued operation of and rate increases for:

(i) Intermediate care facilities for individuals with developmental disabilities;

(ii) Developmental day treatment clinic services provided to persons with developmental disabilities by providers licensed by the Division of Developmental Disabilities Services of the Department of Human Services under § 20-48-101 et seq.; and

(iii) Services provided to persons with developmental disabilities under the Alternative Community Services Waiver Program by providers certified to provide waiver services by the Division of Developmental Disabilities Services of the Department of Human Services;

(B) Expansion of the Alternative Community Services Waiver Program to serve more persons with developmental disabilities than is approved under the waiver program as of March 1, 2009;

(C) The Division of Medical Services of the Department of Human Services; and

(D) Public guardianship of adults.

(b)(1) The designated account moneys in the trust fund from the provider fee on intermediate care facilities for individuals with developmental disabilities that are unused at the end of a fiscal year shall be carried forward.

(2) The designated account moneys in the trust fund from the provider fee on intermediate care facilities for individuals with developmental disabilities may not be used to supplant other local, state, or federal funds.

**History.** Acts 2009, No. 433, § 1.

## SUBCHAPTER 10 — ALTERNATIVE COMMUNITY SERVICES WAIVER PROVIDER FEE

### SECTION.

20-48-1001. Definitions.

20-48-1002. Provider fee.

20-48-1003. Administration.

### SECTION.

20-48-1004. Use of funds.

20-48-1005. Effectiveness and cessation.

**Effective Dates.** Acts 2011, No. 275 § 2: Mar. 15, 2011. Emergency clause provided: "It is found and determined by the General Assembly of the State of Arkansas that a large number of people with disabilities are on a waiting list for home and community-based services; that the payments created in this act will help reduce the waiting list; and that the payments created in this act are immediately necessary to prevent irreparable harm to the individuals with disabilities who are

on the waiting lists. Therefore, an emergency is declared to exist, and this act being immediately necessary for the preservation of the public peace, health, and safety shall become effective on: (1) The date of its approval by the Governor; (2) If the bill is neither approved nor vetoed by the Governor, the expiration of the period of time during which the Governor may veto the bill; or (3) If the bill is vetoed by the Governor and the veto is overridden, the date the last house overrides the veto."



**20-48-1001. Definitions.**

As used in this subchapter:

(1) "Alternative Community Services Waiver Program" means the home and community-based waiver program authorized by the Centers for Medicare & Medicaid Services under § 1915(c) of the Social Security Act, 42 U.S.C. § 1396 et seq., and administered by the Division of Developmental Disabilities Services of the Department of Human Services;

(2)(A) "Gross receipts" means compensation paid to a provider for services provided through, or identical to those provided under, the Alternative Community Services Waiver Program.

(B) "Gross receipts" does not include charitable contributions; and

(3) "Medicaid" means the medical assistance program established by Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq., and administered by the Division of Medical Services of the Department of Human Services.

**History.** Acts 2011, No. 275, § 1.

**20-48-1002. Provider fee.**

(a)(1) There is imposed a provider fee on services provided through, or identical to those provided under, the Alternative Community Services Waiver Program to be calculated in accordance with this section.

(2) The provider fee shall be an amount calculated by the Division of Medical Services of the Department of Human Services to produce a provider fee payment equal to six percent (6%) of the gross receipts received by each provider.

(b)(1)(A) The provider fee shall be payable in monthly payments.

(B) Each monthly payment shall be due and payable for the previous month by the thirtieth day of each month.

(2) The division shall seek approval from the Centers for Medicare & Medicaid Services to treat the provider fee as an allowable cost for Medicaid reimbursement purposes.

(c) A provider of services under the Alternative Community Services Waiver Program shall not be guaranteed, expressly or otherwise, that any additional moneys paid to the provider for services under the Alternative Community Services Waiver Program will equal or exceed the amount of its provider fee.

(d)(1) The division shall ensure that the rate of imposition of the provider fee established in this section equals, but does not exceed, the maximum rate of imposition established under federal law and rule for health care-related provider fees without reduction in federal financial participation in Medicaid.

(2) If the division determines that the rate of imposition of the provider fee established in this section exceeds the maximum rate of imposition that federal law and rule allow for health-care related provider fees without reduction in federal financial participation in

Medicaid, the division shall lower the rate of imposition of the provider fee to a rate that is equal to the maximum rate that federal law and rule allow for health-care related provider fees without reduction in federal financial participation in Medicaid.

**History.** Acts 2011, No. 275, § 1.

### **20-48-1003. Administration.**

(a) The administration of this subchapter shall be exercised by the Director of the Division of Medical Services of the Department of Human Services and shall be subject to the provisions of the Arkansas Administrative Procedure Act, § 25-15-201 et seq.

(b)(1) In accordance with the Arkansas Administrative Procedure Act, § 25-15-201 et seq., the Division of Medical Services of the Department of Human Services shall promulgate rules and prescribe forms for:

(A) The proper imposition and collection of the provider fee;

(B)(i) The enforcement of this subchapter, including without limitation certification nonrenewal, letters of caution, sanctions, or fines.

(ii)(a) The fine for failure to comply with payment and reporting requirements shall be at least one thousand dollars (\$1,000) but no more than one thousand five hundred dollars (\$1,500).

(b) The fine and, if applicable, the outstanding balance of the provider fee shall accrue interest at the maximum rate permitted by law from the date the fine and, if applicable, the provider fee is due until payment of the outstanding balance of the fine and, if applicable, the provider fee;

(C) The format for reporting gross receipts; and

(D) The administration of this subchapter.

(2) The rules shall not grant any exceptions to, or exceptions from, the provider fee.

**History.** Acts 2011, No. 275, § 1.

### **20-48-1004. Use of funds.**

(a)(1) The provider fee imposed and collected under this subchapter shall be deposited into a designated account within the Arkansas Medicaid Program Trust Fund.

(2) The designated account shall be separate and distinct from the general fund and shall be supplementary to the trust fund.

(3) The designated account moneys in the trust fund and the matching federal financial participation under Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq., shall be used only as follows:

(A) For the amount resulting from the first five and one-half percent (5.5%) of the provider fee:

(i) A minimum of fifty percent (50%) shall be used for the support and enhancement of services under the Alternative Community



Services Waiver Program to persons with developmental disabilities; and

(ii) An amount not to exceed fifty percent (50%) may be used by the Division of Medical Services of the Department of Human Services; and

(B) The amount resulting from the next five-tenths of one percent (0.5%) of the provider fee shall be used by the Division of Developmental Disabilities Services of the Department of Human Services for the support of the state’s human development centers.

(b)(1) The designated account moneys in the trust fund from the provider fee imposed and collected under this subchapter that are unused at the end of a fiscal year shall be carried forward.

(2) The designated account moneys in the trust fund from the provider fee imposed and collected under this subchapter may not be used to supplant other local, state, or federal funds.

(3) The designated account moneys in the trust fund from the provider fee imposed and collected under this subchapter shall be exempt from budgetary cuts, reductions, or eliminations caused by a deficiency of general revenues.

**History.** Acts 2011, No. 275, § 1; 2013, substituted “human development centers”  
No. 1132, § 36. for “Human Development Centers” in  
**Amendments.** The 2013 amendment (a)(3)(B).

**20-48-1005. Effectiveness and cessation.**

The imposition imposed under § 20-48-1002 shall not take effect or shall cease to be imposed if the imposition is determined to be an impermissible tax or not eligible for federal financial participation under Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq.

**History.** Acts 2011, No. 275, § 1.

**SUBCHAPTER 11 — MANAGED EXPANSION FOR CHILD HEALTH MANAGEMENT SERVICES**

SECTION.

- 20-48-1101. Legislative intent.
- 20-48-1102. Definitions.
- 20-48-1103. Prerequisites for certification and licensure.
- 20-48-1104. Determination of underserved status for expansion of services.

SECTION.

- 20-48-1105. Order of priority for granting approval.
- 20-48-1106. Notice of underserved area.
- 20-48-1107. Rules.
- 20-48-1108. Successor program.

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**Effective Dates.** Acts 2013, No. 1017, § 3[4]: July 1, 2013. Emergency clause provided: “It is found and determined by the General Assembly of the State of Arkansas that managed expansion of the child health management services program and the developmental day treatment clinic services for children program is in the best interest of children served and critical to economic efficiencies neces-



sary to sustain the Medicaid program; that managed expansion is also necessary to ensure adequate geographic coverage in rural areas; and that the managed expansion rules in place for developmental day treatment clinic services have worked well and should serve as the model for

child health management services or any successor program. Therefore, an emergency is hereby declared to exist and this act being necessary for the immediate preservation of the public peace, health and safety shall become effective on July 1, 2013.”

### **20-48-1101. Legislative intent.**

The intent of this subchapter is to avoid unnecessary expansion in Medicaid costs and services related to child health management services and developmental day treatment clinic services for children or any successor program providing early intervention day treatment to children.

**History.** Acts 2013, No. 1017, § 1.

### **20-48-1102. Definitions.**

As used in this subchapter:

(1) “Accredited entity” means a corporate entity that:

(A) Has successfully completed an ongoing accreditation process that is offered by a national accrediting organization and is:

- (i) Related to the delivery of child health management services;
- (ii) Related to the delivery of developmental day treatment clinic services for children; or

(iii) Related to the delivery of early intervention day treatment services provided by a successor program; and

(B) One or more of the following:

(i) Satisfies all certification criteria established by the Department of Human Services for child health management services;

(ii) Satisfies all licensure criteria for developmental day treatment clinic services for children established by the Division of Developmental Disabilities Services of the Department of Human Services; or

(iii) Satisfies all certification and licensure criteria established by a regulatory entity governing any successor program;

(2) “Child health management services” means an array of clinic services for children:

(A) Intended to provide full medical multidiscipline diagnosis, evaluation, and treatment of developmental delays in Medicaid recipients; and

(B) That is diagnostic, screening, evaluative, preventive, therapeutic, palliative, or rehabilitative services, including early intervention day treatment services;

(3)(A) “Child health management services operated by an academic medical center” means an academic medical center program specializing in developmental pediatrics that is administratively staffed and

operated by an academic medical center and under the direction of a board-certified or board-eligible developmental pediatrician.

(B) An academic medical center consists of a medical school and its primary teaching hospitals and clinical programs.

(C) For a child health management services program operated by an academic medical center, services may be provided at different sites operated by the academic medical center as long as the child health management services program falls under one administrative structure within the academic medical center;

(4) "Developmental day treatment clinic services for children" means early intervention day treatment provided to children by a nonprofit community program that:

(A) Is licensed to provide center-based community services by the Division of Developmental Disabilities Services;

(B) Serves as a quasi-governmental instrumentality of the state by providing support and services to persons who have a developmental disability or delay and would otherwise require support and services through state-operated programs and facilities;

(5)(A) "Early intervention day treatment" means services provided by a pediatric day treatment program run by early childhood specialists, overseen by a physician, and serving children with developmental disabilities, developmental delays, or a medical condition that puts them at risk for developmental delay.

(B) Early intervention day treatment includes without limitation diagnostic, screening, evaluative, preventive, therapeutic, palliative, and rehabilitative and habilitative services, including speech, occupational, and physical therapies and any medical or remedial services recommended by a physician for the maximum reduction of physical or mental disability and restoration of the child to the best possible functional level.

(C) Child health management services and developmental day treatment clinic services or a successor program constitute the state's early intervention day treatment program;

(6) "Existing operations" means services provided by a child health management services program or a developmental day treatment clinic services program that has submitted a completed application to the Division of Medical Services of the Department of Human Services to serve as a Medicaid provider no later than July 1, 2013;

(7) "Medicaid" means the medical assistance program authorized under Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq., and established under § 20-77-101 et seq., that provides for payments for medical goods or services on behalf of indigent families with dependent children and of aged, blind, or disabled individuals whose income and resources are insufficient to meet the cost of necessary medical services;

(8) "National accrediting organization" includes without limitation:

(A) The Commission on the Accreditation of Rehabilitation Facilities; or

(B) Any other similar national accrediting organization recognized by the Division of Developmental Disabilities Services; and



(9) "Successor Program" means a program:

(A) That provides early intervention day treatment to children;

(B) That is created as a replacement for, combination of, or derived in whole or in part from the child health management services program and the developmental day treatment clinic services program for children; and

(C) In which the for-profit and nonprofit providers from child health management services programs and developmental day treatment clinic services programs are eligible to participate.

**History.** Acts 2013, No. 1017, § 1.

### **20-48-1103. Prerequisites for certification and licensure.**

(a)(1)(A) Certification and licensure are required for operation as a child health management services program.

(B) Certification shall be granted on a county-wide basis.

(2) Before obtaining certification, a child health management services program is required to apply to and obtain the approval of the Division of Developmental Disabilities Services of the Department of Human Services to implement new child health management services under the criteria established under this subchapter.

(3) A certified child health management services program with existing operations on July 1, 2013, shall not be required to obtain the approval of the division to continue existing operations.

(b)(1)(A) Licensure from the division is required for operation of a developmental day treatment clinic for children.

(B) The division shall grant licensure on a county-wide basis.

(2) Before obtaining licensure, a nonprofit community program seeking to operate developmental day treatment clinic services for children is required to apply to and obtain the approval of the division to implement new developmental day treatment clinic services for children under the criteria established under this subchapter.

(3) A licensed nonprofit community program providing developmental day treatment clinic services for children with existing operations on July 1, 2013, shall not be required to obtain the approval of the division to continue existing operations.

(c)(1)(A) Licensure or certification from the regulatory authority governing a successor program is required for operation as a successor program.

(B) Licensure or certification shall be granted on a county-wide basis.

(2) Before obtaining licensure or certification, a successor program is required to apply to and obtain the approval of the division to implement new successor program services under the criteria established in this subchapter.

(3) A successor program that was a certified child health management services program with existing operations on July 1, 2013, or a licensed nonprofit community program providing developmental day



treatment clinic services for children with existing operations on July 1, 2013, shall not be required to obtain the approval of the division to continue operations that were in existence on July 1, 2013, but shall be subject to certification or licensure surveys and rules applicable to the successor program.

**History.** Acts 2013, No. 1017, § 1.

**20-48-1104. Determination of underserved status for expansion of services.**

(a) An expansion of early intervention day treatment services in a county is necessary when the Division of Developmental Disabilities Services determines that a county is underserved with regard to:

- (1) Early intervention day treatment services; or
- (2) A specific category of early intervention day treatment services currently offered to children with developmental disabilities or delays.

(b) As a condition of the issuance of a new certification to operate a child health management services program, a new license to operate a developmental day treatment clinic services program for children, or a new certification or license for a successor program, the division must determine that a county of the state is underserved in accordance with subsection (a) of this section.

(c)(1) The division shall have sixty (60) days from the date of an application for expansion of early intervention day treatment services in which to determine whether a county is underserved under subsection (a) of this section.

(2)(A) The division shall provide the applicant with a written report of its findings and conclusions by certified mail.

(B) The division shall provide a copy of the report to the appropriate licensing or certification authority of the applicant.

(3) If the division determines that the county is not underserved under subsection (a) of this section, the applicant shall have thirty (30) days from the date of the applicant's receipt of the written report in which to appeal the determination to the Office of Appeals and Hearings of the Department of Human Services under the Arkansas Administrative Procedure Act, § 25-15-201 et seq.

**History.** Acts 2013, No. 1017, § 1.

**20-48-1105. Order of priority for granting approval.**

(a) When considering an application for approval under this subchapter for expansion of early intervention day treatment services, including child health management services, developmental day treatment clinic services for children, or any successor program services, the Division of Developmental Disabilities Services of the Department of Human Services shall give approval in the following order of preference:

(1) A certified child health management services, a licensed developmental day treatment clinic services for children, or a successor program with existing operations in the county identified by the division as underserved;

(2) A certified child health management services program, a licensed developmental day treatment clinic services for children, or a successor program from another county in the state;

(3) An accredited entity in the underserved county;

(4) An accredited entity from another county in the state; and

(5) An accredited entity from outside the state.

(b) The division shall not require accreditation of the following entities in order to approve the entity's application for expansion of early intervention day treatment services under this subchapter:

(1) A certified child health management services program with existing operations on July 1, 2013;

(2) A licensed nonprofit community program providing developmental day treatment services for children with existing operations on July 1, 2013;

(3) A successor program that was a certified child health management services program with existing operations on July 1, 2013; or

(4) A successor program that was a licensed nonprofit community program providing developmental day treatment services for children with existing operations on July 1, 2013.

**History.** Acts 2013, No. 1017, § 1.

### **20-48-1106. Notice of underserved area.**

(a) The Division of Developmental Disabilities Services of the Department of Human Services shall provide written notice by certified mail of its designation under § 20-48-1104 to all child health management services programs, developmental day treatment clinic services programs for children, and successor programs with existing operations in the county designated by the division as underserved.

(b) If all child health management services programs, developmental day treatment clinic services programs for children, and successor programs with existing operations in the county designated by the division as underserved determine not to expand early intervention day treatment services, including child health management services, developmental day treatment clinic services for children, or successor program services in the underserved county, the division shall provide written notice by certified mail of its designation under § 20-48-1104 to all providers of child health management services, developmental day treatment clinic services for children, and any successor program services in the remainder of the state.

(c) If all child health management services programs, developmental day treatment clinic services programs for children, and successor programs in the remainder of the state determine not to expand early intervention day treatment services, including child health manage-



ment services, developmental day treatment clinic services for children, or successor program services in the underserved county, the division shall provide notice to the general public in a newspaper of statewide general circulation.

**History.** Acts 2013, No. 1017, § 1.

### **20-48-1107. Rules.**

(a) The Division of Developmental Disabilities Services of the Department of Human Services may adopt rules to implement this subchapter.

(b) The division shall work with stakeholders, including without limitation representatives of the Child Health Management Services Association and the Developmental Disabilities Provider Association in the development of rules under this subchapter.

**History.** Acts 2013, No. 1017, § 1.

### **20-48-1108. Successor program.**

(a) On or before July 1, 2013, the Department of Human Services shall convene stakeholders, including without limitation representatives of the Child Health Management Services Association and the Developmental Disabilities Provider Association, to assist in determining the feasibility of combining or merging the child health management services program and the developmental day treatment clinic services program for children into a successor program.

(b)(1) This subchapter does not require a successor program to include child health management services programs operated by an academic medical center.

(2) Child health management services programs operated by an academic medical center shall be subject to all other provisions of this subchapter including without limitation §§ 20-48-1103 and 20-48-1104.

**History.** Acts 2013, No. 1017, § 1.

## **CHAPTER 49**

## **STERILIZATION OF MENTAL INCOMPETENTS**

### **SUBCHAPTER.**

2. STERILIZATION PURSUANT TO PETITION.

3. STERILIZATION PURSUANT TO MEDICAL CERTIFICATION. [REPEALED.]

### **SUBCHAPTER 2 — STERILIZATION PURSUANT TO PETITION**

#### **SECTION.**

20-49-201. Proceedings generally.



**20-49-201. Proceedings generally.**

- (a) The probate court shall have exclusive jurisdiction over all proceedings under this chapter, subject to the right of appeal.
- (b) The venue for all proceedings under this chapter shall be:
  - (1) In the county of this state which is the domicile of the incompetent; or
  - (2) If the incompetent is not domiciled in this state but resides in this state, in the county of his residence.
- (c) The court shall, on its own motion, appoint for the person who is allegedly incompetent a guardian ad litem, in compliance with the procedure set forth by law for infant defendants.

**History.** Acts 1971, No. 433, ch. 5, § 1; in (c), substituted “person who is allegedly” for “alleged” and “by law” for “in § 16-61-108.”  
A.S.A. 1947, § 59-501; Acts 2013, No. 1148, § 58.  
**Amendments.** The 2013 amendment,

**SUBCHAPTER 3 — STERILIZATION PURSUANT TO MEDICAL CERTIFICATION**

SECTION.  
20-49-301 — 20-49-304. [Repealed.]

**20-49-301 — 20-49-304. [Repealed.]**

**Publisher’s Notes.** This subchapter was repealed by Acts 2009, No. 952, §10. The subchapter was derived from the following sources:  
20-49-301. Acts 1971, No. 433, ch. 5, § 2; A.S.A. 1947, § 59-502.  
20-49-302. Acts 1971, No. 433, ch. 5, § 2; A.S.A. 1947, § 59-502.  
20-49-303. Acts 1971, No. 433, ch. 5, § 2; A.S.A. 1947, § 59-502.  
20-49-304. Acts 1971, No. 433, ch. 5, § 2; A.S.A. 1947, § 59-502.

**CHAPTER 50**  
**INTERSTATE COMPACT ON MENTAL HEALTH**

SECTION.  
20-50-102. Compact administrator — Powers and duties.

**20-50-102. Compact administrator — Powers and duties.**

- (a) Pursuant to this compact, the Director of the Division of Behavioral Health Services of the Department of Human Services, or his designee, shall be the compact administrator and, acting jointly with like officers of other party states, shall have power to promulgate rules and regulations to carry out more effectively the terms of the compact.
- (b) The compact administrator is authorized, empowered, and directed to cooperate with all departments, agencies, and officers of and in the government of this state and its subdivisions in facilitating the proper administration of the compact or any supplementary agreements entered into by this state thereunder.

**History.** Acts 1971, No. 433, ch. 9, § 2; A.S.A. 1947, § 59-802; Acts 1995, No. 829, § 1; 2013, No. 980, § 16.

**Amendments.** The 2013 amendment substituted "Behavioral" for "Mental" in (a).

## ***SUBTITLE 4. FOOD, DRUGS, AND COSMETICS***

### **CHAPTER 56**

### **GENERAL PROVISIONS**

#### **SUBCHAPTER.**

#### **2. FOOD, DRUG, AND COSMETIC ACT.**

#### **SUBCHAPTER 2 — FOOD, DRUG, AND COSMETIC ACT**

#### **SECTION.**

20-56-211. Misbranded drug or device.

20-56-214. False or misleading advertisement.

#### **20-56-211. Misbranded drug or device.**

A drug or device shall be deemed to be misbranded:

(1) If its labeling is false or misleading in any particular;

(2) If in package form unless it bears a label containing:

(A) The name and place of business of the manufacturer, packer, or distributor. However, in the case of any drug subject to subdivision (11) of this section, the label shall contain the name and place of business of the manufacturer of the final dosage form of the drug and, if different, the name and place of business of the packer or distributor thereof; and

(B) An accurate statement of the quantity of the contents in terms of weight, measure, or numerical count. Reasonable variations shall be permitted, and exemptions as to small packages shall be established, by regulations prescribed by the State Board of Health;

(3) If any word, statement, or other information required by or under authority of this subchapter to appear on the label or labeling is not prominently placed thereon with such conspicuousness, as compared with other words, statements, designs, or devices in the labeling, and in such terms as to render it likely to be read and understood by the ordinary individual under customary conditions of purchase and use;

(4) If it is for use by man and contains any quantity of narcotic or hypnotic substance, alpha-sucaine, barbituric acid, beta-sucaine, bromal, cannabis, carbromal, chloral, coca, cocaine, codeine, heroin, marijuana, morphine, opium, paraldehyde, peyote, or sulphonmethane, or any chemical derivative of such substances, which derivative has been designated as habit-forming by regulations promulgated under § 502(d) [repealed] of the federal Food, Drug, and Cosmetic Act unless its label bears the name and quantity or proportion of the substance or derivative and in juxtaposition therewith the statement "Warning — May be habit-forming";



(5) If it is a drug and is not designated solely by a name recognized in an official compendium unless its label bears:

(A) The common or usual name of the drug, if there is any; and

(B) In case it is fabricated from two (2) or more ingredients, the common or usual name of each active ingredient, including the kind and quantity or proportion of any alcohol, and also including, whether active or not, the name and quantity or proportion of any bromides, ether, chloroform, acetanilid, acetophenetidin, amidopyrine, antipyrine, atropine, hyoscyne, hyoscyamine, arsenic, digitalis, glucosides, mercury, ouabain, stophanthin, strychnine, thyroid, or any derivative or preparation of any such substances contained therein. However, to the extent that compliance with the requirements of this subdivision is impracticable, exemptions shall be established by regulations promulgated by the board;

(6) Unless its labeling bears:

(A) Adequate directions for use; and

(B) Such adequate warning against use in those pathological conditions or by children where its use may be dangerous to health, or against unsafe dosage or methods or duration of administration or application, in such manner and form as are necessary for the protection of users. However, where any requirement of subdivision (6)(A) of this section as applied to any drug or device is not necessary for the protection of the public health, the board shall promulgate regulations exempting the drug or device from the requirements;

(7) If it purports to be a drug the name of which is recognized in an official compendium, unless it is packaged and labeled as prescribed therein. However, the method of packing may be modified with the consent of the board. Whenever a drug is recognized in both the *United States Pharmacopoeia* and the *Homeopathic Pharmacopoeia of the United States*, it shall be subject to the requirements of the *United States Pharmacopoeia* with respect to packaging and labeling unless it is labeled and offered for sale as a homeopathic drug, in which case it shall be subject to the provisions of the *Homeopathic Pharmacopoeia of the United States* and not to those of the *United States Pharmacopoeia*;

(8) If it has been found by the board to be a drug liable to deterioration, unless it is packaged in such form and manner and its label bears a statement of such precautions as the board shall by regulations require as necessary for the protection of public health. No such regulations shall be established for any drug recognized in an official compendium until the board shall have informed the appropriate body charged with the revision of the compendium of the need for the packaging or labeling requirements and the body shall have failed within a reasonable time to prescribe the requirements;

(9)(A) If it is a drug and its container is so made, formed, or filled as to be misleading;

(B) If it is an imitation of another drug; or

(C) If it is offered for sale under the name of another drug;



(10) If it is dangerous to health when used in the dosage or with the frequency or duration prescribed, recommended, or suggested in the labeling thereof; or

(11) If it is a drug other than those covered by Acts 1951, No. 184 [repealed], and intended for use by man which:

(A) Is a habit-forming drug to which subdivision (4) of this section applies;

(B) Because of its toxicity or other potentiality for harmful effect, or the method of use, or the collateral measures necessary to its use, is not safe for use except under the supervision of a physician, dentist, or veterinarian; or

(C) Is limited by an effective application under § 505 [repealed] of the federal Food, Drug, and Cosmetic Act to use under professional supervision by a physician, dentist, or veterinarian unless it is dispensed only:

(i) Upon a written prescription of a physician, dentist, or veterinarian; or

(ii)(a) By refilling a written or oral prescription if the refilling is authorized by the prescriber.

(b) However, a drug dispensed by filling or refilling a written prescription of a physician, dentist, or veterinarian is exempt from the requirements of this section except subdivisions (1) and (9) of this section if the drug bears a label containing:

(1) The name and address of the dispenser;

(2) The serial number and date of the prescription or its filling;

(3) The name of the prescriber;

(4) If stated in the prescription, the name of the patient; and

(5) The directions for use and cautionary statements, if any, contained in the prescription.

(c) This exemption does not apply to a drug dispensed in the course of the conduct of a business of dispensing drugs pursuant to diagnosis by mail.

**History.** Acts 1953, No. 415, § 15; 1977, No. 938, § 1; A.S.A. 1947, § 82-1115; Acts 2013, No. 1331, §§ 2, 3.

**Amendments.** The 2013 amendment repealed former (11)(C)(ii); redesignated (11)(C)(iii) as present (11)(C)(ii) and added

subdivision designations; and deleted "either in the original prescription or by oral order which is promptly reduced to writing by the pharmacist" at the end of (11)(C)(ii)(a).

## 20-56-214. False or misleading advertisement.

(a) An advertisement of a food, drug, device, or cosmetic shall be deemed to be false if it is false or misleading in any particular.

(b)(1)(A) For the purpose of this subchapter, the advertisement of a drug or device shall also be deemed to be false if the advertisement represents the drug or device to have any effect on any of the following diseases or conditions:

(i) Albuminuria;

(ii) Appendicitis;

- (iii) Arteriosclerosis;
- (iv) Blood poison;
- (v) Bone disease;
- (vi) Bright's disease;
- (vii) Cancer;
- (viii) Carbuncles;
- (ix) Cholecystitis;
- (x) Diabetes;
- (xi) Diphtheria;
- (xii) Dropsy;
- (xiii) Erysipelas;
- (xiv) Gallstones;
- (xv) Heart and vascular diseases;
- (xvi) High blood pressure;
- (xvii) Mastoiditis;
- (xviii) Measles;
- (xix) Meningitis;
- (xx) Mumps;
- (xxi) Nephritis;
- (xxii) Otitis media;
- (xxiii) Paralysis;
- (xxiv) Pneumonia;
- (xxv) Poliomyelitis or infantile paralysis;
- (xxvi) Prostate gland disorders;
- (xxvii) Pyelitis;
- (xxviii) Scarlet fever;
- (xxix) Sexual impotence;
- (xxx) Sexually transmitted disease;
- (xxxi) Sinus infection;
- (xxxii) Smallpox;
- (xxxiii) Tuberculosis;
- (xxxiv) Tumors;
- (xxxv) Typhoid; or
- (xxxvi) Uremia.

(B) An advertisement of a drug or device shall not be deemed to be false under this subsection if the advertisement is disseminated only for the purpose of public health education by persons not commercially interested, directly or indirectly, in the sale of the drug or device.

(2) However, whenever the State Board of Health determines that an advance in medical science has made any type of self-medication safe as to any of the diseases named above, the board shall by regulation authorize the advertisement of drugs having curative or therapeutic effect for the disease, subject to such conditions and restrictions as the board may deem necessary in the interests of public health.

(3) This subsection shall not be construed as indicating that self-medication for diseases other than those named herein is safe or efficacious.

**History.** Acts 1953, No. 415, § 18; A.S.A. 1947, § 82-1118; Acts 2007, No. 827, § 170.

## CHAPTER 57

### REGULATION OF FOOD GENERALLY

SUBCHAPTER.

- 2. FOOD SERVICE ESTABLISHMENTS.
- 4. MISCELLANEOUS FOODS.

#### SUBCHAPTER 2 — FOOD SERVICE ESTABLISHMENTS

SECTION.

- 20-57-201. Definitions.
- 20-57-204. Permit required.

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**Effective Dates.** Acts 2005, No. 394, § 2: Feb. 24, 2005. Emergency clause provided: “It is found and determined by the General Assembly of the State of Arkansas that the regulation of food service establishments must be uniform in order to adequately serve the public good; that this act is necessary in order to avoid a lapse in the uniform application of regulatory requirements to food service establishments. Therefore, an emergency is declared to exist and this act being immediately necessary for the preservation of the public peace, health, and safety shall become effective on: (1) The date of its approval by the Governor; (2) If the bill is neither approved nor vetoed by the Governor, the expiration of the period of time during which the Governor may veto the bill; or (3) If the bill is vetoed by the Governor and the veto is overridden, the date the last house overrides the veto.”

Acts 2011, No. 72, § 2: Feb. 18, 2011. Emergency clause provided: “It is found and determined by the General Assembly of the State of Arkansas that with growing season quickly approaching, a crop could be lost if the effective date of this act is delayed; that a delay in the effective date of this act could cause significant economic hardship for food producers; and that this act is necessary to ensure the maximum positive effect in the community. Therefore, an emergency is declared to exist and this act being immediately necessary for the preservation of the public peace, health, and safety shall become effective on: (1) The date of its approval by the Governor; (2) If the bill is neither approved nor vetoed by the Governor, the expiration of the period of time during which the Governor may veto the bill; or (3) If the bill is vetoed by the Governor and the veto is overridden, the date the last house overrides the veto.”

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#### 20-57-201. Definitions.

As used in §§ 20-57-202 — 20-57-205:

- (1) “Cottage food production operation” means a person who produces food items in the person’s home that are not potentially hazardous foods, including without limitation:
  - (A) Bakery products;
  - (B) Candy;
  - (C) Fruit butter;



(D) Jams;

(E) Jellies; and

(F) Similar products specified in rules adopted by the Department of Health;

(2)(A)(i) "Food service establishment" means any place where food is prepared, processed, stored, or intended for use or consumption by the public regardless of whether there is a charge for the food.

(ii) "Food service establishment" includes wholesale and retail food stores, convenience stores, food markets, delicatessens, restaurants, food processing or manufacturing plants, bottling and canning plants, wholesale and retail block and prepackaged ice manufacturing plants, food caterers, and food warehouses.

(iii) "Food service establishment" does not include supply vehicles or locations of vending machines.

(B) The following are also exempt:

(i) Group homes routinely serving ten (10) or fewer persons;

(ii) Daycare centers routinely serving ten (10) or fewer persons;

(iii) Potluck suppers, community picnics, or other group gatherings where food is served but not sold;

(iv) A person at a farmers' market that offers for sale only one (1) or more of the following:

(a) Fresh unprocessed fruits or vegetables;

(b) Maple syrup, sorghum, or honey that is produced by a maple syrup or sorghum producer or beekeeper; or

(c) Commercially prepackaged food that is not potentially hazardous, on the condition that the food is contained in displays, the total space of which equals less than one hundred cubic feet (100 cu. ft.) on the premises where the person conducts business at the farmers' market;

(v) A person who offers for sale at a roadside stand only fresh fruits and fresh vegetables that are unprocessed;

(vi)(a) A cottage food production operation, on the condition that the operation offers its products directly to the consumer:

(1) From the site where the products are produced;

(2) At a farmers' market;

(3) At a county fair; or

(4) At a special event.

(b)(1) Upon request, each product offered under subdivision (2)(B)(vi)(a) of this section shall be made available to the department for sampling.

(2) Each product shall be clearly labeled and shall make no nutritional claims.

(3) The label required under subdivision (2)(B)(vi)(b)(2) of this section shall include the following:

(A) The name and address of the business;

(B) The name of the product;

(C) The ingredients in the product; and

(D) The following statement in 10-point type: "This Product is Home-Produced";

(vii) A maple syrup and sorghum processor and beekeeper if the processor or beekeeper offers only maple syrup, sorghum, or honey directly to the consumer from the site where those products are processed;

(viii) A person who offers for sale only one (1) or more of the following foods at a festival or celebration, on the condition that the festival or celebration is organized by a political subdivision of the state and lasts for a period not longer than seven (7) consecutive days:

(a) Fresh unprocessed fruits or vegetables;

(b) Maple syrup, sorghum, or honey if produced by a maple syrup or sorghum processor or beekeeper; or

(c) Commercially prepackaged food that is not potentially hazardous, on the condition that the food is contained in displays, the total space of which equals less than one hundred cubic feet (100 cu. ft.);

(ix) A farm market that offers for sale at the farm market only one (1) or more of the following:

(a) Fresh unprocessed fruits or vegetables;

(b) Maple syrup, sorghum, or honey that is produced by a maple syrup or sorghum producer or beekeeper; or

(c) Commercially prepackaged food that is not potentially hazardous, on the condition that the food is contained in displays, the total space of which equals less than one hundred cubic feet (100 cu. ft.) on the premises where the person conducts business at the farm market;

(x) An establishment that offers only prepackaged foods that are not potentially hazardous as defined by the State Board of Health; and

(xi) Ice vending machines or kiosks where ice is dispensed in the open air and that are totally self-contained; and

(3) "Food service industry" means the aggregate of food service establishments.

**History.** Acts 1977, No. 357, § 1; 1979, No. 734, § 1; A.S.A. 1947, § 82-997; Acts 1987, No. 903, § 1; 1989, No. 67, § 1; 1991, No. 378, § 2; 2009, No. 1403, § 1; 2011, No. 72, § 1.

**Amendments.** The 2009 amendment rewrote (1)(B)(iv); added (1)(B)(v); and made related changes.

The 2011 amendment deleted "unless the context otherwise requires" from the introductory paragraph; inserted present (1) and redesignated the remaining subdivisions accordingly; subdivided (2)(A) as (2)(A)(i); and inserted (2)(B)(iv) through (ix) and redesignated the remaining subdivisions accordingly.

## 20-57-204. Permit required.

(a) No food service establishment shall be allowed to operate unless it has procured a food establishment permit from the Division of Environmental Health Protection of the Department of Health.

(b)(1) Permits issued under this section, §§ 20-57-201 — 20-57-203, and 20-57-205 are not transferable, shall be renewed annually, and shall expire one (1) year after issuance or at a time specified by the Department of Health.



(2) A late fee equal to one-half ( $\frac{1}{2}$ ) of the renewal fee for any type of establishment shall be charged to renew a permit sixty (60) days after the expiration date.

(c) Any food service establishment may obtain a food service permit by paying an annual permit fee of thirty-five dollars (\$35.00) to the department and by meeting the minimum requirements established by the applicable rules and regulations.

(d) Each distinctively separate food establishment type and class as defined in §§ 20-57-201 — 20-57-205 shall be required to procure a permit for that type or class per each location not to exceed a total of one hundred five dollars (\$105).

(e)(1) A temporary food establishment permit shall be procured from the division by any temporary facility operating at a fixed location for a period of not more than fourteen (14) consecutive days in conjunction with a single event or celebration.

(2) A fee of five dollars (\$5.00) shall be charged per day for each temporary food establishment permit.

(f) Public school cafeterias shall be exempt from payment of the permit fee but shall submit to inspection pursuant to the rules and regulations of the State Board of Health.

(g) Nonprofit organizations that sell food on a temporary basis for fund-raising events shall be exempt from payment of the permit fee but shall submit to inspection pursuant to the rules of the State Board of Health.

(h) The following shall not be required to obtain permits, pay fees, or submit to inspections by the department but may seek the advice and assistance of the department:

(1) Potluck suppers;

(2) Community picnics; or

(3) Other group gatherings where food is served but not sold.

(i) Any retail food store having gross sales of less than one hundred fifty thousand dollars (\$150,000) must obtain a food service permit but shall be exempt from payment of the permit fee.

(j) Any bottler of water that is not a resident of this state shall obtain a permit from the department in order to sell its bottled water within this state. The bottler shall submit to the department annually a bacteriological analysis conducted by a laboratory approved by the department, a certificate of operation from the bottler's resident state, and a permit fee of fifty dollars (\$50.00).

**History.** Acts 1977, No. 357, § 3; 1980 (1st Ex. Sess.), No. 20, § 1; A.S.A. 1947, § 82-997.2; Acts 1987, No. 903, § 3; 1989, No. 67, § 3; 1991, No. 378, § 3; 1993, No. 130, § 1; 1993, No. 146, § 1; 1995, No. 168, § 1; 1997, No. 102, § 1; 1999, No. 217, §§ 1, 2; 2001, No. 467, § 1; 2001, No. 546, § 1; 2005, No. 394, § 1; 2009, No. 1403, § 2; 2011, No. 226, § 1; 2011, No. 1121, § 13.

**Amendments.** The 2009 amendment deleted "and regulations" at the end of (c) and (d)(2); substituted "July 1, 2013" for "July 1, 2009" in (d)(2); inserted present (g) and redesignated the remaining subsections accordingly; rewrote (h); deleted "the Division of Sanitarian Services of" preceding "the Department of Health" in (j); and made minor stylistic changes in (b)(1).



The 2011 amendment by No. 226 deleted (d)(2).

The 2011 amendment by No. 1121, in (b)(1), inserted "this section" and substi-

tuted "20-57-201 — 20-57-203, and 20-57-205" for "20-57-201 — 20-57-205."

## SUBCHAPTER 4 — MISCELLANEOUS FOODS

### SECTION.

20-57-402. Honey.

### 20-57-402. Honey.

(a) Unless the product is pure honey manufactured by honeybees, it is unlawful for any person to:

(1) Package any product and label the product as "honey" or "imitation honey" or to use the word "honey" in any prominent location on the label of the product; or

(2) Sell or offer for sale any product that is labeled "honey" or "imitation honey" or which contains a label with the word "honey" prominently displayed thereon.

(b)(1) Any person violating the provisions of this section shall be guilty of a violation and upon conviction shall be punished by a fine of not less than fifty dollars (\$50.00) nor more than five hundred dollars (\$500).

(2) Each violation shall constitute a separate offense.

**History.** Acts 1973, No. 513, §§ 1, 2; A.S.A. 1947, §§ 82-985, 82-986; Acts 2005, No. 1994, § 130.

## CHAPTER 58

## EGGS

### SUBCHAPTER.

1. GENERAL PROVISIONS.

2. ARKANSAS EGG MARKETING ACT.

## SUBCHAPTER 1 — GENERAL PROVISIONS

### SECTION.

20-58-101. [Repealed.]

### 20-58-101. [Repealed.]

**Publisher's Notes.** This section, concerning marking of cold-storage eggs, was repealed by Acts 2013, No. 1145, § 3. This section was derived from Acts 1931, No.

223, §§ 1, 2; Pope's Dig., §§ 3467, 3468; A.S.A. 1947, §§ 82-932, 82-933; Acts 2005, No. 1994, § 131.

**SUBCHAPTER 2 — ARKANSAS EGG MARKETING ACT**

## SECTION.

20-58-204. Penalties.

**20-58-204. Penalties.**

(a) Any person, firm, or corporation violating any of the provisions of this subchapter or regulations of the Arkansas Livestock and Poultry Commission shall be guilty of a violation and shall upon conviction:

(1) For the first offense be fined not less than twenty-five dollars (\$25.00) nor more than one hundred dollars (\$100);

(2) For the second offense be fined not less than one hundred dollars (\$100) nor more than two hundred fifty dollars (\$250); and

(3) For the third offense be fined not less than two hundred fifty dollars (\$250) nor more than five hundred dollars (\$500).

(b) In addition to fines, in the discretion of the court:

(1) For the first offense, his or her permit may be suspended not more than thirty (30) days;

(2) For the second offense, his or her permit may be suspended not more than sixty (60) days; and

(3) For the third offense or any subsequent offense, his or her grading and packing permit may be revoked.

(c) Public notice shall be made upon conviction of violation under this subchapter.

**History.** Acts 1969, No. 220, § 19;  
A.S.A. 1947, § 82-1322; Acts 2005, No.  
1994, § 132.

**CHAPTER 59****MILK AND DAIRY PRODUCTS**

## SUBCHAPTER.

1. GENERAL PROVISIONS.

2. REGULATION OF MANUFACTURE AND SALE GENERALLY.

3. MELLORINE.

4. GRADE "A" MILK PROGRAM ACT.

**SUBCHAPTER 1 — GENERAL PROVISIONS**

## SECTION.

20-59-102. [Repealed.]

**20-59-102. [Repealed.]**

**Publisher's Notes.** This section, concerning ownership of Little Rock Milk Program assets, was repealed by Acts

2013, No. 1145, § 4. This section was derived from Acts 1977, No. 409, § 3; A.S.A. 1947, § 82-4003.

**SUBCHAPTER 2 — REGULATION OF MANUFACTURE AND SALE GENERALLY**

## SECTION.

20-59-202. Penalties.

20-59-248. Incidental sales of goat milk

and whole milk that has  
not been pasteurized not  
prohibited.

**20-59-202. Penalties.**

Any person, firm, or corporation shall be guilty of a violation and shall be fined a sum not less than twenty-five dollars (\$25.00) nor more than three hundred dollars (\$300) if that person, firm, or corporation shall:

(1) Hinder, obstruct, or in any way interfere with the Director of the Department of Health or his or her deputies while discharging the duties of inspection;

(2) Obstruct or hinder in any way the director from carrying out the full meaning and intent of this subchapter;

(3) Refuse or fail to make the reports provided for by §§ 20-59-206 — 20-59-211 and 20-59-214 — 20-59-246;

(4) Refuse or neglect to conform to the rules and regulations of the Department of Health that have been published as provided in this subchapter regarding the care or condition of any animal kept for dairy purposes or for the sanitary conditions of any room, building, or place where dairy products are kept either for storage or for the purpose of sale and distribution; or

(5) Sell, exhibit, or offer for sale any dairy product that is adulterated.

**History.** Acts 1941, No. 114, § 5; A.S.A. 1947, § 82-916; Acts 2005, No. 1994, § 133.

**20-59-248. Incidental sales of goat milk and whole milk that has not been pasteurized not prohibited.**

(a) For purposes of this section:

(1) “Incidental sales of goat milk and whole milk that has not been pasteurized” are those sales where the average monthly number of gallons sold does not exceed five hundred (500) gallons;

(2) “Locally produced whole milk products” means whole milk that has been produced on an Arkansas farm; and

(3)(A) “Whole milk” means the lacteal secretion obtained by the complete milking of one (1) or more healthy cows, properly fed and kept, that when offered for sale contains at least three and one-fourth percent (3.25%) of butterfat and eight and one-fourth percent (8.25%) solids not fat.

(B) “Whole milk” does not include lacteal secretion obtained within fifteen (15) days before or five (5) days after calving or a longer period if necessary to render the milk practically colostrum free.



(b) This subchapter does not prohibit incidental sales of raw goat milk and whole milk that has not been pasteurized directly to consumers at the farm where the milk is produced or preclude the advertising of incidental sales of goat milk and whole milk that has not been pasteurized.

(c) With respect to whole milk that has not been pasteurized, the seller shall:

(1) Post at the point of sale a sign that is no smaller than two feet (2') by four feet (4') that includes the following information in large, clear text:

(A) The name and address of the farm with seller's contact information; and

(B) The following statement:

"This product, sold for personal use and not for resale, is fresh whole milk that has NOT been pasteurized. Neither this farm nor the milk sold by this farm has been inspected by the State of Arkansas. The consumer assumes all liability for health issues that may result from the consumption of this product."; and

(2) Affix a label to the bottle or package that includes:

(A) The name and address of the farm; and

(B) The following statement:

"This product, sold for personal use and not for resale, is fresh whole milk that has NOT been pasteurized. Neither this farm nor the milk sold by this farm has been inspected by the State of Arkansas. The consumer assumes all liability for health issues that may result from the consumption of this product."

(d) A farmer who sells fresh whole unpasteurized milk shall permit inspection of his or her cows and barns by his or her customers upon request.

**History.** Acts 1993, No. 816, § 1; 2013, No. 1209, § 1.

**Amendments.** The 2013 amendment inserted "and whole milk that has not been pasteurized" after "goat milk"

throughout the section; subdivided part of (a) as (a)(1); substituted "five hundred (500)" for "one hundred (100)" in present (a)(1); and added (a)(2), (a)(3), (c), and (d).

### SUBCHAPTER 3 — MELLORINE

#### SECTION.

20-59-302. Penalties.

#### 20-59-302. Penalties.

(a) Any person, firm, or corporation that violates any of the provisions of this subchapter or any of the rules and regulations issued in connection therewith or any officer, agent, or employee thereof who directs or knowingly permits such a violation or who aids or assists such a violation shall be guilty of a violation and upon conviction shall be subject to a fine of not more than two hundred fifty dollars (\$250) and not less than fifty dollars (\$50.00).

(b) Each violation shall constitute a separate offense.

**History.** Acts 1953, No. 416, § 13; A.S.A. 1947, § 82-918.12; Acts 2005, No. 1994, § 134.

#### SUBCHAPTER 4 — GRADE “A” MILK PROGRAM ACT

##### SECTION.

20-59-404. Inspection fees.

#### **20-59-404. Inspection fees.**

(a) In order to make the Grade “A” Milk and Milk Products Inspection and Regulation Program self-supporting, the Accounting Division of the Department of Health shall collect on a monthly basis unless otherwise stated the following Grade “A” milk and milk products inspection fees:

(1) Producers shall pay \$.030 per one hundred pounds (100 lbs.) of Grade “A” milk inspected by the state.

(2) Importers of raw Grade “A” milk produced and inspected in another state and imported into Arkansas as raw Grade “A” milk shall pay an inspection fee of ten dollars (\$10.00) for each sample analyzed by the laboratory of the Department of Health.

(3) Milk plants shall pay \$.030 per one hundred pounds (100 lbs.) of Grade “A” milk processed or distributed.

(4) Producer-distributors shall pay \$.065 per one hundred pounds (100 lbs.) of Grade “A” milk produced or sold.

(5) Milk haulers who sample and transport Grade “A” milk in the state shall pay an annual permit fee of ten dollars (\$10.00). The fee shall be due January 1 of each year.

(6) Distributors of Grade “A” milk processed by plants outside of Arkansas and sold in the state shall pay \$.030 per one hundred pounds (100 lbs.) or a monthly minimum fee of two hundred dollars (\$200) per month plus ten dollars (\$10.00) for each sample analyzed by the laboratory of the department. The larger of the two (2) sums shall be paid during the following month.

(7) Single service plants shall pay an annual permit fee of two hundred dollars (\$200). This fee shall not be applied to plants paying a milk inspection fee. The fee shall be due January 1 of each year.

(b) If any person fails, neglects, or refuses to pay the above fee and is delinquent for a period of thirty (30) days, the Director of the Department of Health is directed and empowered to prohibit the person from distributing, hauling, selling, or otherwise handling Grade “A” milk or milk products in the state and shall suspend his or her permit and withdraw all inspection service from the establishment until fees are paid in full.

(c)(1) The Grade “A” milk and milk products inspection fees shall not be greater than the actual cost of the inspections.

(2) If there is a balance in the Milk Inspection Fees Fund equivalent to ninety-day maintenance of the Arkansas Grade "A" Milk Program, one (1) month of the milk inspection fees shall be forgiven.

(d) The fees set forth in subsection (a) of this section may be increased by up to one half cent (\$.005) beginning July 1, 1992, upon certification by the Chief Fiscal Officer of the State that the expenditures of the Arkansas Grade "A" Milk Program exceed the amount of fees collected. Any request for an increase in fees shall be reviewed by the Grade "A" Milk Program Advisory Committee.

**History.** Acts 1981, No. 587, §§ 3, 4; A.S.A. 1947, §§ 82-4008, 82-4009; Acts 1987, No. 634, § 1; 1991, No. 191, § 1.

**Publisher's Notes.** This section is being set out to reflect corrections in (a)(1), (a)(3), (a)(4) and (a)(6).

## CHAPTER 60

### MEAT AND MEAT PRODUCTS

#### SUBCHAPTER.

#### 1. GENERAL PROVISIONS.

#### SUBCHAPTER 1 — GENERAL PROVISIONS

#### SECTION.

20-60-101. Use of imported meat in food establishment.

#### SECTION.

20-60-102. Arkansas bacon.

#### 20-60-101. Use of imported meat in food establishment.

(a)(1) As used in this section, "food service establishment" means any:

(A) Fixed or mobile restaurant, coffee shop, cafeteria, short-order cafe, luncheonette, grille, tearoom, soda fountain, sandwich shop, hotel kitchen, smorgasbord, tavern, bar, cocktail lounge, night club, roadside stand, industrial feeding establishment, school lunch project, private, public, or nonprofit organization or institution routinely serving the public, catering kitchen, commissary, or similar place in which the food or drink is prepared for sale or for service on the premises or elsewhere;

(B) Grocery store, delicatessen, meat market, retail bakery, or other establishment that sells or otherwise provides food for immediate or on-premise consumption, regardless of whether serving food for immediate consumption is the primary activity of the business; or

(C) Eating and drinking establishment where food is served or provided for the public with or without charge.

(2) The following places where food is served shall be exempt from the definition of a food service establishment:

(A) Group homes routinely serving ten (10) or fewer persons;

(B) Day care centers routinely serving ten (10) or fewer persons;

(C) Potluck suppers, community picnics, or other group gatherings where food is served but not sold;



(D) Nonprofit organizations that sell food on a temporary basis for fund-raising events; and

(E) Hospital kitchens and nursing home kitchens.

(b) Each food service establishment shall indicate on its menu or on a notice prominently placed in the establishment whether beef imported from outside the United States is served if the proprietor of the establishment knowingly, willfully, and consistently serves imported beef.

(c) Any person found guilty of violating this section shall be guilty of a violation and upon conviction fined ten dollars (\$10.00) for the first offense and twenty dollars (\$20.00) for the second or subsequent offense.

**History.** Acts 1979, No. 595, §§ 1-3; A.S.A. 1947, §§ 82-980 — 82-980.2; Acts 2005, No. 1994, § 135.

## **20-60-102. Arkansas bacon.**

(a)(1) The term “Arkansas bacon” shall not be used to identify any meat product other than the pork shoulder blade Boston roast prepared in the State of Arkansas in accordance with this section.

(2) Pork shoulder blade Boston roast prepared outside the State of Arkansas but in the manner prescribed by this section may be identified as “Arkansas-style bacon”.

(b)(1) “Arkansas bacon” and “Arkansas-style bacon” are produced from the pork shoulder blade Boston roast by removing the neck bones and rib bones by cutting close to the underside of those bones, removing the blade bone or scapula, and removing the dorsal fat covering, including the skin or clear plate, and leaving no more than one-quarter inch ( $\frac{1}{4}$ ”) of the fat covering the roast.

(2)(A) The meat is then dry-cured with salt, sugar, nitrites, and spices, and smoked with natural smoke.

(B) The meat may not be injected or soaked in curing brine, nor may any artificial or liquid smoke be applied to the meat.

(3) The pork shoulder blade Boston roast includes the porcine muscle, fat, and bone cut interior of the second or third thoracic vertebrae and posterior of the atlas joint or first cervical vertebrae and dorsal of the center of the humerus bone.

(c) Any person who labels or otherwise identifies meat contrary to the provisions of this section shall be guilty of a violation punishable by a fine not to exceed one thousand dollars (\$1,000).

**History.** Acts 1987, No. 326, §§ 1-3; 2005, No. 1994, § 135.

## CHAPTER 61

### FISH AND SEAFOOD

#### SUBCHAPTER.

1. GENERAL PROVISIONS.
2. ARKANSAS CATFISH MARKETING ACT OF 1975.
3. CATFISH — IDENTIFICATION BY RESTAURANTS.

#### SUBCHAPTER 1 — GENERAL PROVISIONS

#### SECTION.

20-61-101. Foreign fish.

#### 20-61-101. Foreign fish.

(a) No fresh, cold storage, or frozen fish produced outside this state or in any foreign country and imported into the United States shall be sold or offered for sale in this state by any food establishment unless:

(1) The package or container containing the food bears a statement in writing naming thereon the country of origin, the date of packaging, and the common name of all fish contained therein; and

(2) The fish has been packaged and processed under sanitary conditions equal to the standards required by the laws and regulations of this state for fish processing plants.

(b)(1) Outlets serving cooked, fresh, cold storage, or frozen fish at retail which display on the menu or in some conspicuous public place in the outlet the identity of the country of origin and the common name of all fish as reflected on the menu or sold in the outlet shall be deemed as having satisfied the requirements of subdivision (a)(1) of this section.

(2) All suppliers of any fresh, cold storage, or frozen fish shall furnish to the distributor or retailer to which the products are sold in this state an affidavit that all products are properly labeled, as required in this section, with respect to the country of origin of and the contents of any foreign imported fish. This affidavit shall include a certificate that the supplier has caused each of the products to be properly labeled in conformance with the requirements of this section.

(3)(A) The Director of the Arkansas Bureau of Standards and enforcement personnel of the bureau are authorized to enforce the requirements of subsection (a) and subdivisions (b)(1) and (2) of this section.

(B) The director is authorized to promulgate rules and regulations necessary to enforce subsection (a) and subdivisions (b)(1) and (2) of this section.

(4) In addition, all suppliers of any fresh, cold storage, or frozen fish shall furnish to any distributor or retailer to which the product is sold in this state proof that the fish has been packaged and processed under sanitary conditions equal to the sanitary conditions required of fish processing plants in this state. The proof may be upon certification by the Department of Health or certification by the United States Food

and Drug Administration or other appropriate federal agency that the processing plant in which the fish was packaged or processed meets sanitary conditions within at least the minimum requirements of the laws and regulations of this state for fish processing plants, or proof may be upon the certification of the supplier that the fish packaged or processed outside this state or in a foreign country was packaged or processed in a fish processing plant that meets at least the minimum requirements of the laws and regulations of this state for sanitary conditions for fish processing plants.

(c) Any supplier of fresh, cold storage, or frozen fish or any distributor or retailer who sells any fish in this state in violation of the provisions of this section shall each be individually and severally subject to the civil penalties as provided in subsection (d) of this section.

(d)(1) A violator of this section shall be assessed by the State Plant Board a civil penalty of:

(A) Not less than one hundred dollars (\$100) nor more than three hundred dollars (\$300) for a first violation;

(B) Not less than four hundred dollars (\$400) nor more than six hundred dollars (\$600) for a second violation within three (3) years after the date of the first violation; and

(C) Not less than seven hundred dollars (\$700) nor more than one thousand dollars (\$1,000) for a third violation within three (3) years after the date of the first violation.

(2) For a violation to be considered as a second or subsequent offense, it must be a repeat violation of a requirement enumerated in subsection (a) and subdivisions (b)(1) and (2) of this section.

(3)(A) Any person subject to a civil penalty shall have a right to request an administrative hearing within ten (10) calendar days after receipt of the notice of the penalty.

(B) The board is authorized to conduct the hearing after giving appropriate notice, and its decision shall be subject to judicial review.

(4)(A) If a violator has exhausted the administrative appeals and the civil penalty is upheld, the violator shall pay the civil penalty within twenty (20) calendar days after the date of the final decision.

(B) If the violator fails to pay the penalty, a civil action may be brought by the board in any court of competent jurisdiction to recover the penalty.

(C) Any civil penalty collected under this section shall be transmitted to the State Plant Board Fund.

(e) The provisions of this section shall not be applicable to shellfish.

**History.** Acts 1971, No. 367, §§ 1-3;  
1973, No. 519, § 1; A.S.A. 1947, §§ 82-982  
— 82-984; Acts 2003, No. 1024, § 1.



**SUBCHAPTER 2 — ARKANSAS CATFISH MARKETING ACT OF 1975**

## SECTION.

20-61-202. Definitions.

20-61-203. Penalties — Injunction.

**20-61-202. Definitions.**

As used in this subchapter, unless the context otherwise requires:

(1) "Capable of use as human food" shall mean and shall apply to any catfish or part or product thereof unless it is denatured or otherwise identified as required by regulations prescribed by the Director of the Arkansas Bureau of Standards to deter its use as human food or unless it is naturally inedible by humans;

(2) "Catfish" means any species of the scientific family Ictaluridae;

(3) "Director" means the Director of the Arkansas Bureau of Standards;

(4) "Direct retail sale" means the sale of catfish products individually or in small quantities directly to the consumer;

(5) "Distributor" means any person offering for sale, exchange, or barter any catfish product destined for direct retail sale in Arkansas;

(6) "Label" means a display of written, printed, or graphic matter upon or affixed to the container in which a catfish product is offered for direct retail sale;

(7) "Labeling" means all labels and other written, printed, or graphic matter upon a catfish product, or any of its containers or wrappers, offered for direct retail sale;

(8) "Pay pond" means a circumscribed body of water owned by a person and operated solely for recreational fishing purposes on a commercial basis for profit;

(9) "Person" shall include any individual, partnership, corporation, and association or other legal entity;

(10) "Processor" means any person engaged in handling, storing, preparing, manufacturing, packing, or holding catfish products;

(11) "Producer" means any person engaged in the business of harvesting catfish, by any method, intended for direct retail sale;

(12) "Product" means any catfish product capable of use as human food which is made wholly or in part from any catfish or portion thereof, except products which contain catfish only in small proportions or which in the judgment of the director historically have not been considered by consumers as products of the commercial catfish industry and which are exempted from definition as a catfish product by the director under such conditions as he or she may prescribe to assure that the catfish or portions thereof contained therein are not adulterated and that the products are not represented as catfish products;

(13) "Product name" means the name of the catfish item intended for retail sale which identifies it as to kind, class, or specific use; and

(14) "Retailer" means any person offering for sale catfish products to individual consumers and representing the last sale prior to human consumption.

**History.** Acts 1975 (Extended Sess., 989; reen. Acts 1987, No. 1005, § 3; 2003, 1976), No. 1209, § 3; A.S.A. 1947, § 82- No. 1024, §§ 2, 3.

### **20-61-203. Penalties — Injunction.**

(a)(1)(A) Any person who violates any provision of this subchapter for which no civil penalty is provided by this subchapter shall upon conviction be guilty of a violation and subject to a fine of not more than five hundred dollars (\$500).

(B) However, no person shall be subject to penalties under this section for receiving for transportation any article in violation of this subchapter if the receipt was made in good faith unless the person refuses to furnish on request of a representative of the Director of the Arkansas Bureau of Standards the name and address of the person from whom he or she received the article and copies of all documents, if there are any, pertaining to the delivery of the article to him or her.

(2) All distributors, processors, wholesalers, or retailers who are distributing or selling species of fish as catfish that are not within the definition of "catfish" under § 20-61-202 shall be in violation of this subchapter and shall be assessed a civil penalty of:

(A) Not less than five hundred dollars (\$500) nor more than one thousand dollars (\$1,000) for a first violation;

(B) Not less than eight hundred dollars (\$800) nor more than two thousand dollars (\$2,000) for a second violation within three (3) years after the date of the first violation; and

(C) Not less than one thousand five hundred dollars (\$1,500) nor more than two thousand five hundred dollars (\$2,500) for a third violation within three (3) years after the date of the first violation.

(3) For a violation to be considered as a second or subsequent violation, it must be a repeat of the violation in subdivision (a)(2) of this section.

(4)(A) Any person subject to a civil penalty shall have a right to request an administrative hearing within ten (10) calendar days after receipt of the notice of the penalty.

(B) The State Plant Board is authorized to conduct the hearing after giving appropriate notice, and its decision shall be subject to judicial review.

(5)(A) If a violator has exhausted the administrative appeals and the civil penalty is upheld, the violator shall pay the civil penalty within twenty (20) calendar days after the date of the final decision.

(B) If the violator fails to pay the penalty, a civil action may be brought by the board in any court of competent jurisdiction to recover the penalty.

(C) Any civil penalty collected under this section shall be transmitted to the State Plant Board Fund.

(b) Nothing in this subchapter shall be construed as requiring the director to report for prosecution or for the institution of libel or injunction proceedings any minor violations of this subchapter whenever he or she believes that the public interest will be adequately served by a suitable written notice of warning.



(c)(1) It shall be the duty of each prosecuting attorney to whom any violation is reported to cause appropriate proceedings to be instituted and prosecuted in a court of competent jurisdiction without delay.

(2) Before the director reports a violation for prosecution, an opportunity shall be given the distributor or other affected person to present his or her views to the director.

(d)(1) The director is authorized to apply for and the court to grant a temporary or permanent injunction restraining any person from violating or continuing to violate any of the provisions of this subchapter or any rule or regulation promulgated under this subchapter, notwithstanding the existence of other remedies at law.

(2) The injunction shall be issued without bond.

**History.** Acts 1975 (Extended Sess., 993; reen. Acts 1987, No. 1005, § 7; 2003, 1976), No. 1209, § 7; A.S.A. 1947, § 82- No. 1024, § 4; 2005, No. 1994, § 136.

### SUBCHAPTER 3 — CATFISH — IDENTIFICATION BY RESTAURANTS

#### SECTION.

20-61-301. Penalty — Injunction.

20-61-302. Identification required.

#### 20-61-301. Penalty — Injunction.

(a) Any person who knowingly violates any provision of this subchapter for which no civil penalty is provided by this subchapter shall upon conviction be guilty of a violation and subject to a fine of not more than fifty dollars (\$50.00) for the first offense and not more than five hundred dollars (\$500) for the second and subsequent offenses.

(b) Nothing in this subchapter shall be construed as requiring the Director of the Arkansas Bureau of Standards to report for prosecution or for the institution of libel or injunction proceedings any minor violations of this subchapter whenever he or she believes that the public interest will be adequately served by a suitable written notice of warning.

(c)(1) It shall be the duty of each prosecuting attorney to whom any violation is reported to cause appropriate proceedings to be instituted and prosecuted in a court of competent jurisdiction without delay.

(2) Before the director reports a violation for prosecution, an opportunity shall be given the affected person to present his or her views to the director.

(d)(1) The director is authorized to apply for and the court is authorized to grant a temporary or permanent injunction restraining any person from violating or continuing to violate any of the provisions of this subchapter or any rule or regulation promulgated under this subchapter, notwithstanding the existence of other remedies at law.

(2) The injunction shall be issued without bond.



**History.** Acts 1981, No. 77, § 4; A.S.A. 1947, § 82-995.4; Acts 2005, No. 1994, § 137.

### **20-61-302. Identification required.**

(a) No catfish product shall be offered for direct retail sale for human consumption by a restaurant or other eating establishment unless the catfish product name is identified on the menu in the following manner:

(1) “Farm-Raised Catfish”, if the product has been specifically produced in fresh water according to the usual and customary techniques of commercial aquaculture;

(2) “River or Lake Catfish”, if the product has been produced in any freshwater lake, river, or stream of the state, but has not been produced according to the usual and customary techniques of commercial aquaculture;

(3) “Imported Catfish”, if the catfish product is produced from fresh water, either according to the usual and customary techniques of aquaculture, in or from freshwater lakes, rivers, or streams of a country other than the United States; and

(4) “Ocean Catfish”, if the catfish product is produced from marine or estuarine waters.

(b)(1) Restaurants serving multiple entrees from multiple sources may make a general disclosure of sources upon the menu and shall not be required to disclose the source of each entree. The disclosure shall contain these words: “Upon request of the customer, the origin of each entree will be disclosed”.

(2) Upon request of the customer, the specific source shall be disclosed.

(c) As used in this subchapter, “catfish” means the same as defined under the Arkansas Catfish Marketing Act of 1975, § 20-61-201 et seq.

**History.** Acts 1981, No. 77, § 1; A.S.A. 1947, § 82-995.1; Acts 2003, No. 1024, § 5.

## **CHAPTER 62**

### **POISONS**

#### **SECTION.**

20-62-101. Labels on certain drugs required.

### **20-62-101. Labels on certain drugs required.**

(a) It shall be unlawful to sell at retail arsenic and its compounds, strychnine and its salts, corrosive sublimate, hydrocyanic acid, phosphorus, opium, morphine, laudanum, or any preparation of opium containing over two (2) grains to the ounce without the container being

plainly labeled in English with the name of the article, the name of the seller, and the word "POISON".

(b) Any person who violates any of the provisions of this section shall be guilty of a violation and upon conviction be sentenced to pay a fine of not less than twenty-five dollars (\$25.00) nor more than one hundred dollars (\$100) for each offense.

**History.** Acts 1899, No. 147, §§ 3, 4, p. Dig., §§ 10858, 10859; A.S.A. 1947, §§ 82-268; C. & M. Dig., §§ 8282c, 8282d; Pope's 942, 82-943; Acts 2005, No. 1994, § 138.

## CHAPTER 64

### ALCOHOL AND DRUG ABUSE

#### SUBCHAPTER.

1. GENERAL PROVISIONS.
2. UNIFORM NARCOTIC DRUG ACT.
3. ARKANSAS DRUG ABUSE CONTROL ACT.
6. ALCOHOL AND DRUG ABUSE PREVENTION GENERALLY.
7. ALCOHOLICS.
8. ALCOHOL OR DRUG ADDICTS.
9. ALCOHOL AND DRUG ABUSE TREATMENT PROGRAM LICENSING.
10. ALCOHOL AND DRUG ABUSE COORDINATING COUNCIL.
11. TASK FORCE ON SUBSTANCE ABUSE PREVENTION.

#### SUBCHAPTER 1 — GENERAL PROVISIONS

##### SECTION.

20-64-103. [Repealed.]

#### 20-64-103. [Repealed.]

**Publisher's Notes.** This section, concerning professional use of THC for cancer patients, was repealed by Acts 1987, No. 52, § 2. The section was derived from Acts 1981, No. 8, §§ 1, 2; A.S.A. 1947, §§ 82-1007.1, 82.1007.2.

This Publisher's Note is being set out to correct a reference to the original repealing language.

#### SUBCHAPTER 2 — UNIFORM NARCOTIC DRUG ACT

##### SECTION.

20-64-201. Definitions.  
20-64-210. Labels.

##### SECTION.

20-64-217. Fraud or deceit.

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**Publisher's Notes.** For Comments regarding the Uniform Narcotic Drug Act, see Commentaries Volume B.

**20-64-201. Definitions.**

The following words and phrases, as used in this subchapter, shall have the following meanings, unless the context otherwise requires:

(1) "Apothecary" means a licensed pharmacist as defined by the laws of this state and, where the context so requires, the owner of a store or other place of business where narcotic drugs are compounded or dispensed by a licensed pharmacist; but nothing in this subchapter shall be construed as conferring on a person who is not registered nor licensed as a pharmacist any authority, right, or privilege that is not granted to him by the pharmacy laws of this state;

(2) "Dentist" means a person authorized by law to practice dentistry in this state;

(3) "Dispense" includes distribute, leave with, give away, dispose of, or deliver;

(4) "Federal narcotic laws" means the laws of the United States relating to opium, coca leaves, and other narcotic drugs;

(5) "Hospital" means an institution for the care and treatment of the sick and injured, approved by the Director of the Department of Health as proper to be entrusted with the custody of narcotic drugs and the professional use of narcotic drugs under the direction of a physician, dentist, or veterinarian;

(6) "Laboratory" means a laboratory approved by the Director of the Department of Health as proper to be entrusted with the custody of narcotic drugs and the use of narcotic drugs for scientific and medical purposes and for purposes of instruction;

(7) "Manufacturer" means a person who, by compounding, mixing, cultivating, growing, or other process, produces or prepares narcotic drugs, but does not include an apothecary who compounds narcotic drugs to be sold or dispensed on prescriptions;

(8)(A) "Narcotic drug" means any drug which is defined as a narcotic drug by order of the Director of the Department of Health. In the formulation of definitions of narcotic drugs, the Director of the Department of Health is directed to include all drugs which he finds are narcotic in character and by reason thereof are dangerous to the public health or are promotive of addiction-forming or addiction-sustaining results upon the user which threaten harm to the public health, safety, or morals. In formulating these definitions, the Director of the Department of Health shall take into consideration the provisions of the federal narcotic laws as they exist, from time to time, and shall amend the definitions so as to keep them in harmony with the definitions prescribed by the federal narcotic laws, so far as is possible under the standards established in this subdivision, and under the policy of this subchapter.

(B) "Narcotic drug" also means any of the following, whether produced directly or indirectly by extraction from substances of vegetable origin or independently by means of chemical synthesis, or by a combination of extraction and chemical synthesis:



(i) Opium, opiates, derivatives of opium and opiates, including their isomers, esters, and ethers whenever the existence of such isomers, esters, ethers, and salts is possible within the specific chemical designation. This term does not include the isoquinoline alkaloids of opium;

(ii) Poppy straw and concentrate of poppy straw;

(iii) Coca leaves, except coca leaves and extracts of coca leaves from which cocaine, ecgonine, and derivatives of ecgonine or their salts have been removed;

(iv) Cocaine, its salts, optical and geometric isomers, and salts of isomers;

(v) Ecgonine, its derivatives, their salts, isomers, and salts of isomers;

(vi) Any compound, mixture, or preparation which contains any quantity of any of the substances referred to in subdivisions (8)(B)(i)-(v) of this section.

(9)(A) "Official written order" means an order written on a form provided for that purpose by the Director of the Drug Enforcement Administration under the laws of the United States making provision therefor, if order forms are authorized and required by federal law and, if an order form is not provided, then on an official form provided for that purpose by the Director of the Department of Health.

(B) When permitted by federal law, an official written order may also be written and submitted electronically;

(10) "Person" includes any corporation, association, copartnership, or one (1) or more individuals;

(11) "Physician" means a person authorized by law to practice medicine in this state and any other person authorized by law to treat sick and injured human beings in this state and to use narcotic drugs in connection with such treatment;

(12) "Registry number" means the number assigned to each person registered under the federal narcotic laws;

(13) "Sale" includes barter, exchange, or gift, or offer therefor, and each such transaction made by any person, whether as principal, proprietor, agent, servant, or employee;

(14) "Veterinarian" means a person authorized by law to practice veterinary medicine in this state;

(15) "Wholesaler" means a person who supplies narcotic drugs that he himself has not produced nor prepared, on official written orders, but not on prescriptions; and

(16) "Written prescription" means a prescription that is presented to an apothecary in compliance with federal law and regulations, including a written, oral, faxed, or electronic prescription.

**History.** Acts 1937, No. 344, § 1; Pope's Dig., §§ 4615, 10126; Acts 1941, No. 324, §§ 1, 2; 1955, No. 155, § 1; 1959, No. 250, § 1; 1965, No. 409, § 1; A.S.A 1947, § 82-1001; Acts 1987, No. 42, § 1; 2013, No. 1331, §§ 4, 5.

**Amendments.** The 2013 amendment added the (9)(A) designation; in (9)(A),

substituted "the laws" for "any laws" and "if order forms are authorized and required by federal law, if an order form is provided" for "if such order forms are

authorized and required by federal law and, if no such order form is not provided"; and added (9)(B) and (16).

### 20-64-210. Labels.

(1) Whenever a manufacturer sells or dispenses a narcotic drug, and whenever a wholesaler sells or dispenses a narcotic drug in a package prepared by him, he shall securely affix to each package in which that drug is contained a label showing in legible English the name and address of the vendor and the quantity, kind, and form of narcotic drug contained therein. No person, except an apothecary for the purpose of filling a prescription under this subchapter, shall alter, deface, or remove any label so affixed.

(2)(A) When an apothecary sells or dispenses a narcotic drug on a prescription issued by a physician, dentist, or veterinarian, he or she shall affix to the container in which the drug is sold or dispensed a label showing:

(i) His or her own name, address, and registry number, or the name, address, and registry number of the apothecary for whom he or she is lawfully acting;

(ii) The name and address of the patient or, if the patient is an animal, the name and address of the owner of the animal and the species of the animal;

(iii) The name, address, and registry number of the physician, dentist, or veterinarian from whom the prescription was prescribed; and

(iv) The directions for the use of the prescription.

(B) A person shall not alter, deface, or remove a label affixed as required under this subdivision (2).

**History.** Acts 1937, No. 344, § 10; Pope's Dig., § 10135; A.S.A. 1947, § 82-1010; Acts 2013, No. 1331, § 6.

**Amendments.** The 2013 amendment added subdivision designations; inserted

"or she" following "he" in (2)(A) and (2)(A)(i); substituted "prescribed" for "written" in (2)(A)(iii); substituted "for the use of" for "as may be stated on" in (2)(A)(iv); and rewrote (2)(B).

### 20-64-217. Fraud or deceit.

(1) No person shall obtain or attempt to obtain a narcotic drug, or procure or attempt to procure the administration of a narcotic drug:

(a) by fraud, deceit, misrepresentation, or subterfuge; or

(b) by the forgery or alteration of a prescription or of any order; or

(c) by the concealment of a material fact; or

(d) by the use of a false name or the giving of a false address.

(2) Information communicated to a physician in an effort unlawfully to procure a narcotic drug, or unlawfully to procure the administration of any such drug, shall not be deemed a privileged communication.

(3) No person shall willfully make a false statement in any prescription, order, report, or record, required by this subchapter.

(4) No person shall, for the purpose of obtaining a narcotic drug, falsely assume the title of, or represent himself to be, a manufacturer, wholesaler, apothecary, physician, dentist, veterinarian, or other authorized person.

(5) A person shall not make or utter a false or forged prescription or false or forged order.

(6) No person shall affix any false or forged label to a package or receptacle containing narcotic drugs.

(7) The provisions of this section shall apply to all transactions relating to narcotic drugs under the provisions of § 20-64-208, in the same way as they apply to transactions under all other sections.

**History.** Acts 1937, No. 344, § 17; Pope's Dig., § 10142; A.S.A. 1947, § 82-1017; Acts 2013, No. 1331, §§ 7, 8.

**Amendments.** The 2013 amendment deleted "written" following "of any" in (1)(b) and following "or forged" in (5).

### SUBCHAPTER 3 — ARKANSAS DRUG ABUSE CONTROL ACT

#### SECTION.

20-64-314. Depressant and stimulant

drugs — Limitations on filling of prescriptions.

#### 20-64-302. Definitions.

#### RESEARCH REFERENCES

**ALR.** Validity, Construction, and Application of State Trademark Counterfeiting Statutes. 63 A.L.R.6th 303.

#### 20-64-306. Prohibited acts.

#### RESEARCH REFERENCES

**ALR.** Validity, Construction, and Application of State Trademark Counterfeiting Statutes. 63 A.L.R.6th 303.

#### 20-64-308. Seizure and forfeiture of contraband — Hearing and disposition.

#### RESEARCH REFERENCES

**ALR.** Evidence considered in tracing currency, bank account, or cash equivalent to illegal drug trafficking so as to permit forfeiture, or declaration as contraband, under state law — Proximity of asset to drugs, paraphernalia, or records. 115 A.L.R.5th 403.

Evidence considered in tracing currency, bank account, or cash equivalent to illegal drug trafficking so as to permit forfeiture, or declaration as contraband, under state law — Odor of drugs. 116 A.L.R.5th 325.



**20-64-314. Depressant and stimulant drugs — Limitations on filling of prescriptions.**

(a)(1)(A) A prescription for a depressant or stimulant drug shall not be filled or refilled more than six (6) months after the date on which the prescription was issued.

(B) A prescription that is authorized to be refilled shall not be refilled more than five (5) times.

(2) However, this subchapter does not prevent a practitioner from issuing a new written prescription for the same drug.

(b) If no indication of refill status is indicated on the prescription, it shall not be refilled.

**History.** Acts 1967, No. 492, § 7; A.S.A. 1947, § 82-2107; Acts 2013, No. 1331, § 9. added subdivision designations; deleted “and no” at the end of (a)(1)(A); and re-wrote (a)(2).

**SUBCHAPTER 6 — ALCOHOL AND DRUG ABUSE PREVENTION GENERALLY****SECTION.**

20-64-601. [Repealed.]

20-64-602. Division of Behavioral Health Services — Powers and duties.

**20-64-601. [Repealed.]**

**Publisher’s Notes.** This section, concerning creation of the Office of Alcohol and Drug Abuse Prevention, was repealed by Acts 2013, No. 1107, § 19. This section derived from Acts 1977, No. 644, § 1; A.S.A. 1947, § 82-2132 Acts 2007, No. 251, § 4; 2007, No. 827, § 171.

**20-64-602. Division of Behavioral Health Services — Powers and duties.**

(a) The Division of Behavioral Health Services shall:

(1) Coordinate all state and federally funded programs dealing with alcohol and drug abuse in the state;

(2) Provide information to the public on the problems and needs of alcohol and drug abusers;

(3) Make evaluations of the effectiveness and efficiency of various agencies and programs relating to alcohol and drug abuse; and

(4) Exercise all authority not inconsistent with the provisions of this subchapter as may be necessary to carry out the purposes and intent of this subchapter.

(b) The duties and responsibilities of the division shall include the following:

(1) Coordinate all state and federally funded programs, services, and activities relating to the prevention, treatment, rehabilitation, education intervention, and training of alcoholics and persons with alcohol and other drug abuse-related problems;

(2) Develop, administer, and implement a state plan for alcohol abuse and drug abuse prevention as defined in Pub. L. No. 92-255, or its successor, and develop reports on state and local activities in alcohol and drug abuse prevention with recommendations for allocations of resources by refining goals and establishing priorities;

(3) Sponsor, encourage, and conduct research into the causes, nature, and treatment of alcoholism, alcohol abuse, and drug abuse and serve as a central source of information and data collection regarding alcohol abuse and drug abuse in this state;

(4) Serve in a liaison capacity between the state and local communities and federal government with respect to alcohol abuse and drug abuse programs and, subject to the approval of the Director of the Department of Human Services, enter into agreements with and make commitments on behalf of the State of Arkansas to meet requirements for obtaining federal assistance or grants for partially financing alcohol abuse and drug abuse programs in the state;

(5) Divide the state into appropriate regions for the purpose of planning and the provision of services;

(6) As may be deemed necessary, establish district, regional, or other substate advisory councils to help carry out the duties of the division;

(7) Review, on a continuing basis, existing and proposed state statutes relating to alcohol abuse and drug abuse education, prevention, intervention, treatment rehabilitation, and training and make appropriate recommendations for legislation to the director and the General Assembly;

(8) Review, on a continuing basis, existing and proposed rules, policies, programs, and procedures of state agencies and political subdivisions concerning alcohol and drug abuse and recommend to the appropriate agency or political subdivision changes in or additions to the rules, policies, programs, and procedures;

(9) Review those budget items proposed by other state agencies which are intended for alcohol or drug abuse prevention, intervention, treatment, education, rehabilitation, and training services and make recommendations to the Director of the Department of Human Services;

(10) Determine the training and orientation needs of professionals, paraprofessionals, supervisors, managers, and other persons in the public and private sectors who come in contact with those persons affected directly or indirectly with alcohol or drug abuse problems or who may impact in a preventive way with individuals who might otherwise become dependent upon alcohol or other drugs;

(11) Assist in the development of programs designed to meet identified needs;

(12) Provide technical assistance, guidance, consultation, information, and other appropriate services to local programs, local government, district and regional bodies, and state agencies regarding the creation or modification of alcohol or drug abuse programs and procedures;



(13) Establish and apply criteria for evaluation of:

(A) The effectiveness of alcohol or drug abuse programs conducted in this state; and

(B) The accuracy of information contained in and the effectiveness of literature and audiovisual aids prepared to combat alcohol and drug abuse;

(14) Specify uniform methods for keeping statistical information on all individuals receiving services related to the use or misuse of alcohol and drugs and also develop and maintain a centralized data collection and dissemination system for alcohol and drug abuse programs and activities consistent with federal and state statutes and regulations;

(15) Prepare an annual report to coincide with appropriate federal reports to be submitted to the advisory council, the director, and the Governor describing activities of the division and the accomplishments and effectiveness of its programs and also prepare special reports as deemed necessary for the advisory council to aid in the fulfillment of its advisory responsibilities;

(16) Develop policies, plans, and programs sponsoring and encouraging research and prevention activities in this state, especially in the categories of children and youth, women, minorities, senior citizens, and incarcerated persons but not limited to these areas;

(17) Request, as deemed necessary, reports in sufficient detail for various departments of state government regarding their alcohol or drug abuse program activities;

(18) Cooperate with and assist and solicit the cooperation and assistance of appropriate state agencies, community mental health centers and clinics, hospitals, doctors, law enforcement officials, courts, ministers, and any and all other public or private agencies or organizations involved in or dedicated to providing services to those persons who have alcohol or drug abuse-related problems;

(19) Develop and promulgate standards, rules, and regulations for accrediting, certifying, and licensing alcohol and drug abuse prevention, treatment, and rehabilitation programs and facilities within the state, under the supervision and direction of the director, provided that the standards, rules, and regulations shall not supersede standards, rules, and regulations promulgated by other state agencies for programs or facilities whose primary mission is not alcohol and drug abuse prevention, treatment, and rehabilitation;

(20) Review the regulations, guidelines, requirements, and procedures of state and federally funded operating agencies in terms of their consistency with state alcohol and drug abuse prevention policies, priorities, procedures, and objectives and assist the agencies in making changes therein as may be appropriate;

(21) Maintain a liaison with all state and local agencies concerned with drug traffic prevention;

(22) Conduct annual site visits to all state and federally funded alcohol and drug abuse programs and facilities to determine their compliance with the standards, rules, and regulations for accrediting, certifying, and licensing as set forth in subdivision (19) of this section;



(23) Apply for and assist others in applying for state, private, or federal grants-in-aid and, with the advice and counsel of the advisory council, approve applications for state and federal grants and enter into grants and contracts with public agencies, institutes of higher learning, and private organizations or individuals for the purpose of carrying out research, prevention, education, training, treatment, intervention, and rehabilitation activities or special projects which bear directly on the problems related to alcohol and drug abuse or misuse. The contracts or grants may be entered into for these purposes without performance bonds;

(24) Be the primary agency responsible for receiving and disbursing all state, federal, and other public moneys collected for the purpose of combating alcohol and drug abuse-related problems in this state and to account for such receipts and disbursals as are made; and

(25) Do and perform all other actions and exercise all other authority not inconsistent with the provisions of this subchapter as may be necessary to carry out the purposes and intent of this subchapter.

**History.** Acts 1977, No. 644, § 1; A.S.A. 1947, § 82-2132; Acts 2013, No. 1107, § 20.

**Amendments.** The 2013 amendment substituted “Division of Behavioral Health Services” for “Bureau of Alcohol and Drug Abuse Prevention” in the section

heading; substituted “Division of Behavioral Health Services” for “Bureau of Alcohol and Drug Abuse Prevention” in the introductory language of (a); and substituted “division” for “bureau” in the introductory language of (b), (b)(6), and (b)(15).

## SUBCHAPTER 7 — ALCOHOLICS

### SECTION.

20-64-704. Division of Behavioral Health Services — Powers and duties.

20-64-705. Division of Behavioral Health Services — Power to accept gifts.

### SECTION.

20-64-706. Division of Behavioral Health Services — Rules and regulations.

20-64-707. Division of Behavioral Health Services — Cooperation by other departments.

## 20-64-704. Division of Behavioral Health Services — Powers and duties.

The Division of Behavioral Health Services shall have the following duties and functions:

(1) Carry on a continuing study of the problems of alcoholism in this state and seek to focus public attention on the problems;

(2) Establish cooperative relationships with other state and local agencies, hospitals, clinics, public health, welfare, and law enforcement authorities, educational and medical agencies and organizations, and other related public and private groups;

(3) Promote or conduct educational programs on alcoholism, purchase and provide books, films, and other educational material, furnish funds or grants to the Department of Education, institutions of higher

education, and medical schools for study and research, and modernize instruction regarding the problems of alcoholism;

(4) Provide for treatment and rehabilitation of alcoholics and allocate funds for:

(A) The establishment of local alcoholic clinics, with or without short-term hospitalization facilities, by providing funds for not to exceed seventy-five percent (75%) of the total operating cost of the clinics operated by a city or a county;

(B) Providing treatment for those alcoholics needing from five (5) to ninety (90) days' hospitalization, whether voluntary patients or those admitted on court order, by furnishing the Department of Human Services State Institutional System Board all of the funds needed for the proper operation of segregated wards for treatment of the patients. The funds and necessary personnel shall be in addition to all funds and personnel provided the hospital board in the regular departmental appropriation bill;

(C) Contracting with hospitals or institutions not under its control for the care, custody, and treatment of alcoholics;

(D) Providing for the detention, care, and treatment of recalcitrant alcoholics and alcoholics with long police court records, by furnishing funds for the operation of farm or colony-type facilities under the provisions of subdivision (4)(A) or (B) of this section;

(5) While the division necessarily must, and does, have discretion as to proportions in which it allocates funds to the various aspects of this problem, it is contemplated and intended that the division shall make every reasonable effort not to concentrate too largely on any one (1) phase of the problem at the expense or detriment of other phases. For example, but not limited to, the following phases:

(A) That research should not be retarded because of funds directed to treatment, and vice versa;

(B) That treatment should not be retarded because of funds directed to rehabilitation, and vice versa; and

(C) That rehabilitation should not be retarded because of funds directed to research, and vice versa.

**History.** Acts 1955, No. 411, § 5; A.S.A. substituted "division" for "bureau" 1947, § 83-705; Acts 2013, No. 1107, § 21. throughout (5).

**Amendments.** The 2013 amendment

## **20-64-705. Division of Behavioral Health Services — Power to accept gifts.**

(a)(1) The deputy director, on behalf of the Division of Behavioral Health Services, may receive any federal means, grants, contributions, gifts, and loans which are payable or distributable to the State of Arkansas by the United States or any of its agencies or instrumentalities, under any existing or future federal laws or statutes or rules or regulations of the agencies or instrumentalities, received for or on account of any of the functions performable by the division.



(2) The division may also receive gifts, grants, donations, fees, conveyances, or transfers of money and property, both real and personal, from private and public sources, to effectuate the purposes of this subchapter.

(b) The deputy director, on behalf of the division, shall sell or dispose of such real or personal property as the division deems advisable, upon specific authorization of the division.

(c) Any funds and income from any property so furnished or transferred to the deputy director on behalf of the division shall be placed in the State Treasury in a special fund called the Alcohol and Drug Abuse Prevention Fund Account and expended in the same manner as other state moneys are expended, upon warrants drawn by the comptroller upon the order of the division.

(d) Any of the moneys, funds, and property described in this section are appropriated for the purpose of carrying out the provisions of this subchapter.

**History.** Acts 1955, No. 411, § 7; A.S.A. 1947, § 83-707; Acts 2013, No. 1107, § 22.

**Amendments.** The 2013 amendment substituted “Division of Behavioral Health Services” for “Bureau of Alcohol and Drug Abuse Prevention” in the section

heading; substituted “Division of Behavioral Health Services” for “bureau” in (a)(1); and substituted “division” for “bureau” once in (a)(1), (a)(2) and throughout (b) and (c).

## 20-64-706. Division of Behavioral Health Services — Rules and regulations.

The Division of Behavioral Health Services shall be responsible for the adoption of all policies and shall make all rules and regulations appropriate to the proper accomplishment of its functions under this subchapter and to the allocation of its funds.

**History.** Acts 1955, No. 411, § 8; A.S.A. 1947, § 83-708; Acts 2013, No. 1107, § 23.

**Amendments.** The 2013 amendment substituted “Division of Behavioral

Health Services” for “Bureau of Alcohol and Drug Abuse Prevention” in the section.

## 20-64-707. Division of Behavioral Health Services — Cooperation by other departments.

(a) To effectuate the purpose of this subchapter and to make maximum use of existing facilities and personnel, it shall be the duty of all departments and agencies of the state government and all officers and employees of the state, when requested by the Division of Behavioral Health Services, to cooperate with it in all activities consistent with their proper respective functions.

(b) Nothing in this section shall be construed as giving the division control over existing facilities, institutions, or agencies, or as requiring the facilities, institutions, or agencies to serve the division inconsistently with their respective functions, or with the authority of their respective offices, or with the laws and regulations governing their



respective activities, or as giving the division power to make use of any private institution or agency without the consent of the private institution or agency, or to pay a private institution or agency for services which a public institution or agency is willing and able to perform adequately.

**History.** Acts 1955, No. 411, § 6; A.S.A. 1947, § 83-706; Acts 2013, No. 1107, § 24.

**Amendments.** The 2013 amendment substituted “Division of Behavioral

Health Services” for “Bureau of Alcohol and Drug Abuse Prevention” in the section heading and (a); and substituted “division” for “bureau” throughout (b).

## SUBCHAPTER 8 — ALCOHOL OR DRUG ADDICTS

### SECTION.

20-64-801. Definitions.

20-64-803. Civil immunity.

20-64-805. Inspections — Procedures.

20-64-821. Initial hearing — Determination — Evaluation.

### SECTION.

20-64-830. Liability for treatment — Rules.

### 20-64-801. Definitions.

As used in this subchapter:

(1) “Administrator” refers to the chief administrative officer or executive director of any private or public facility or program designated as a receiving facility or program by the Division of Behavioral Health Services;

(2) “Detention” refers to any confinement of a person against his or her wishes and begins either:

(A) When a person is involuntarily brought to a receiving facility or program;

(B) When the person appears for the initial hearing; or

(C) When a person on a voluntary admission is in a receiving facility or program pursuant to § 20-64-810;

(3) “Evaluation” means an assessment prepared by a receiving facility to include a description of the existence and extent of the person’s addiction to alcohol or drugs;

(4) “Gravely disabled” refers to a person who, if allowed to remain at liberty, is substantially likely, by reason of addiction to alcohol or other drugs, to physically harm himself or herself or others as a result of inability to make a rational decision to receive medication or treatment, as evidenced by:

(A) Inability to provide for his or her own food, clothes, medication, medical care, or shelter;

(B) An inability to avoid or protect himself or herself from severe impairment or injury without treatment; or

(C) Placement of others in a reasonable fear of violent behavior or serious physical harm to them;

(5) “Homicidal” refers to a person who is addicted to alcohol or drugs and poses a significant risk of physical harm to others as manifested by

recent overt behavior evidencing homicidal or other violent assaultive tendencies;

(6) “Person” shall mean a citizen of the State of Arkansas who is eighteen (18) years of age or older;

(7) “Receiving facility or program” refers to a residential, inpatient, or outpatient treatment facility or program which is designated within each geographical area of the state by the division to accept the responsibility for care, custody, and treatment of persons voluntarily admitted or involuntarily committed to the facility or program; and

(8) “Suicidal” refers to a person who is addicted to alcohol or other drugs and by reason thereof poses a substantial risk to himself or herself as manifested by evidence of, threats of, or attempts at suicide or serious self-inflicted bodily harm, or by evidence of other behavior or thoughts that create a grave and imminent risk to his or her physical condition.

**History.** Acts 1989 (3rd Ex. Sess.), No. 10, § 1; 1991, No. 150, § 1; 1995, No. 1268, § 1; 2013, No. 1107, §§ 25, 26.

**Amendments.** The 2013 amendment substituted “Division of Behavioral

Health Services” for “Bureau of Alcohol and Drug Abuse Prevention” in (1); deleted (2) and redesignated the remaining subdivisions accordingly; and substituted “division” for “bureau” in (8).

## 20-64-803. Civil immunity.

The prosecuting attorney, deputy prosecuting attorneys, the Office of the Prosecutor Coordinator, law enforcement officers, governing boards of the Division of Behavioral Health Services, employees of the division, governing boards of designated receiving facilities, and employees of designated receiving facilities and programs shall be immune from civil liability for performance of duties imposed by this subchapter.

**History.** Acts 1989 (3rd Ex. Sess.), No. 10, § 19; 1995, No. 1268, § 2; 1997, No. 1246, § 1; 2013, No. 1107, § 27.

**Amendments.** The 2013 amendment

substituted “Division of Behavioral Health Services” for “Bureau of Alcohol and Drug Abuse Prevention” and “division” for “bureau.”

## 20-64-805. Inspections — Procedures.

(a) To assure compliance with this subchapter, the Division of Behavioral Health Services, through its authorized agents, may visit or investigate any receiving program or facility to which persons are admitted or committed under this subchapter.

(b) The division shall promulgate written procedures to implement this subchapter on or before July 1, 1995. The provisions shall:

(1) Designate receiving facilities and programs within prescribed geographical areas of the state for purposes of voluntary admissions or involuntary commitments under this subchapter; and

(2) Establish ongoing mechanisms, guidelines, and regulations for review and refinement of the treatment programs offered in the receiving facilities and programs for alcohol and other drug abuse throughout this state.



**History.** Acts 1989 (3rd Ex. Sess.), No. 10, § 21; 1995, No. 1268, § 3; 2013, No. 1107, § 28.

**Amendments.** The 2013 amendment substituted “Division of Behavioral Health Services” for “Bureau of Alcohol and Drug Abuse Prevention” in (a); and substituted “division” for “bureau” in (b).

### **20-64-821. Initial hearing — Determination — Evaluation.**

(a) In each case a hearing shall be set by the court within five (5) days, excluding weekends and holidays, of the filing of a petition for involuntary commitment, with a request for continued detention or for involuntary commitment with a request for immediate detention.

(b)(1)(A) A person named in a petition for involuntary commitment who is placed in immediate detention pending a hearing may undergo a screening and assessment within twenty-four (24) hours of the immediate detention.

(B)(i) Except as provided in subdivision (b)(1)(C) of this section, a screening and assessment shall be conducted by a contractor with the Division of Behavioral Health Services.

(ii) The division shall assign contractors to conduct screenings and assessments under this subdivision (b)(1).

(iii) The division shall assume the cost of the screening and assessment.

(C)(i) If a person named in a petition for involuntary commitment who is placed in immediate detention pending a hearing declines a screening and assessment by a contractor with the division under subdivision (b)(1)(B) of this section, the person may undergo a screening and assessment by a qualified professional of his or her choosing within twenty-four (24) hours of the immediate detention.

(ii) The person named in the petition for involuntary commitment shall assume the cost of a screening and assessment by a qualified professional of his or her choosing.

(2)(A) The person conducting a screening and assessment under subdivision (b)(1) of this section shall provide a copy of the results of the screening and assessment to the person named in the petition for involuntary commitment and the prosecuting attorney.

(B)(i) The prosecuting attorney may provide a copy to the court.

(ii) The court may consider the contents of the screening and assessment as part of its determination of whether the standards for involuntary commitment apply to the person.

(c) The person named in the original petition may be removed from the presence of the court upon finding that his or her conduct before the court is so disruptive that proceedings cannot be reasonably continued with him or her present.

(d) The petitioner shall appear before the probate judge to substantiate the petition. The court shall make a determination based upon clear and convincing evidence that the standards for involuntary commitment apply to the person. If such a determination is made, the person shall be remanded to a designated agent of the division or the designated receiving facility for treatment for a period of up to twenty-one (21) days.



- (e) Every person remanded for treatment shall have a treatment plan within twenty-four (24) hours of detention.
- (f) A copy of the court order committing the person to the designated receiving facility for treatment shall be forwarded to the designated receiving facility within five (5) working days.

**History.** Acts 1989 (3rd Ex. Sess.), No. 10, § 10; 1991, No. 150, § 3; 1997, No. 1246, § 4; 2011, No. 1140, § 1; 2013, No. 1107, § 29.

**Amendments.** The 2011 amendment inserted present (b) and redesignated the remaining subsections accordingly; substituted “Office of Alcohol and Drug Abuse Prevention” for “Bureau of Alcohol and Drug Abuse Prevention” in present (d);

and substituted “a treatment plan within twenty-four (24) hours” for “an evaluation within forty-eight (48) hours” in present (e).

The 2013 amendment substituted “Division of Behavioral Health Services” for “Bureau of Alcohol and Drug Abuse Prevention” in (b)(1)(B)(i); and substituted “division” for “office” throughout the section.

20-64-830. Liability for treatment — Rules.

- (a)(1) Any person legally obligated to support a person in treatment from a receiving facility or program shall pay to the facility or program an amount to be fixed by the facility or program as the cost for treatment.
- (2) The amounts shall be a debt of the obligor.
- (b)(1) The Division of Behavioral Health Services shall promulgate rules specifying the amounts to be fixed as costs and establishing procedures for implementation of this section.
- (2) The rules shall set forth costs by reference to the income and assets of the obligor.

**History.** Acts 1989 (3rd Ex. Sess.), No. 10, § 22; 1995, No. 1268, § 8; 2013, No. 1107, § 30.

**Amendments.** The 2013 amendment

substituted “Division of Behavioral Health Services” for “Bureau of Alcohol and Drug Abuse Prevention” in (b)(1).

SUBCHAPTER 9 — ALCOHOL AND DRUG ABUSE TREATMENT PROGRAM  
LICENSING

SECTION.	SECTION.
20-64-901. Purpose.	20-64-906. Disposition of funds.
20-64-902. Definition.	20-64-907. Reporting requirements.
20-64-903. Authority — Exemptions — Current programs.	20-64-908. Appeal process.
20-64-904. Licenses.	20-64-910. Task Force on Substance Abuse Treatment Services.
20-64-905. Renewal.	20-64-911. Purpose.

**A.C.R.C. Notes.** References to “this subchapter” in §§ 20-64-901 through 20-64-909 may not apply to §§ 20-64-910 and

20-64-911, which were enacted subsequently.

**20-64-901. Purpose.**

The purpose of this subchapter is to require all persons, partnerships, associations, or corporations holding themselves out to the public as alcohol and drug abuse treatment programs in the State of Arkansas to meet the licensure standards set by the Division of Behavioral Health Services of the Department of Human Services, unless expressly exempted by this subchapter.

**History.** Acts 1995, No. 173, § 1; 2011, No. 228, § 1; 2013, No. 1107, § 31.

**Amendments.** The 2011 amendment substituted “Office” for “Bureau” and inserted “of the Division of Behavioral Health Services of the Department of Human Services.”

The 2013 amendment deleted “an” following “public as” and “the Office of Alcohol and Drug Abuse Prevention of” following “standards set by” and substituted “programs” for “program.”

**20-64-902. Definition.**

An “alcohol and drug abuse treatment program” means a program that renders or offers to render to a person or group of persons any service that assists the person or group to develop an understanding of alcoholism and drug dependency problems and to define goals and plan courses of action reflecting the person’s or group’s interests, abilities, and needs as affected by alcoholism and drug dependency problems. The definition includes actions taken with the intent of the cessation of harmful or addictive use of alcohol or other drugs. It includes, but is not restricted to, one (1) or more of the following:

- (1) Counseling with individuals, families, or groups;
- (2) Helping persons or families obtain other services appropriate to alcoholism and drug abuse rehabilitation; and
- (3) Engaging in alcoholism and drug abuse research, education, or prevention through the administration of alcoholism and drug abuse counseling.

**History.** Acts 1995, No. 173, § 2; 2013, No. 1132, § 37.

substituted “means” for “is” in the introductory language; and designated former (A) through (C) as present (1) through (3).

**Amendments.** The 2013 amendment

**20-64-903. Authority — Exemptions — Current programs.**

(a)(1) The Division of Behavioral Health Services of the Department of Human Services shall adopt rules for the licensure of alcohol and drug abuse treatment programs in Arkansas.

(2) All persons, partnerships, associations, or corporations establishing, conducting, managing, or operating and holding themselves out to the public as alcohol abuse, drug abuse, or alcohol and drug abuse treatment programs shall be licensed by the division unless expressly exempted under this subchapter.

(3) No person, partnership, association, or corporation will be allowed to receive federal or state funds for treatment services until it has received a license.

(b) The following programs and persons are exempted from the requirements of this subchapter:

(1) Acute care, hospital-based alcohol and drug abuse treatment programs governed by §§ 20-9-201 and 20-10-213;

(2) Members of the clergy, Christian Science practitioners, and licensed professionals working within the standards of their respective professions, including without limitation:

- (A) Attorneys;
- (B) Counselors;
- (C) Nurses;
- (D) Physicians;
- (E) Psychological examiners;
- (F) Psychologists;
- (G) School counselors; and
- (H) Social workers;

(3) Treatment directly administered by the United States Department of Defense or any other federal agency; and

(4) Self-help or twelve-step programs such as Alcoholics Anonymous, Cocaine Anonymous, Narcotics Anonymous, Al-Anon, or Nar-Anon.

(c)(1) The division shall license programs, other than methadone programs, that possess current unrestricted alcohol and drug abuse treatment program accreditation from the Joint Commission, the Commission on Accreditation of Rehabilitation Facilities, or the Council on Accreditation if the programs comply with the following license standards:

- (A) Clinical supervision;
- (B) Health and safety;
- (C) Physical plant;
- (D) Progress note development;
- (E) Treatment plan development; and
- (F) Treatment plan review.

(2)(A) This subsection does not apply to methadone treatment programs operating in the State of Arkansas.

(B) All methadone treatment programs shall be licensed by the division.

**History.** Acts 1995, No. 173, §§ 3, 4; 1999, No. 12, § 1; 2003, No. 761, § 1; 2011, No. 228, § 2; 2013, No. 1107, § 32; 2013, No. 1132, § 38.

**Amendments.** The 2011 amendment substituted “of the Division of Behavioral Health Services of the Department of Human Services shall adopt” for “is vested with the authority and duty to establish and promulgate” in (a)(1); added “unless expressly exempted under this subchapter” in (a)(2); in (b)(2), deleted “such as physicians, nurses, psychologists, coun-

selors, social workers, psychological examiners, school counselors, substance abuse counselors, and attorneys” preceding “working within” and inserted “including without limitation”; added (b)(2)(A) through (H); rewrote (c)(1); and deleted “and alpha acetylmethadol” following “methadone” in (c)(2)(A) and (c)(2)(B).

The 2013 amendment by No. 1107 deleted “Office of Alcohol and Drug Abuse Prevention of the” following “The” in (a)(1); and substituted “division” for “office” throughout the section.



The 2013 amendment by No. 1132 substituted “Nar-Anon” for “Narc-Anon” in (b)(4).

### 20-64-904. Licenses.

(a)(1) A person who immediately before July 28, 1995, was accredited to establish, conduct, manage, or operate an alcohol and drug abuse treatment program under former § 20-64-901 et seq., shall be issued a license under this subchapter without a fee.

(2) The license shall be subject to be renewed at the time that the accreditation would have been due for renewal.

(b)(1) Any person or program desiring to be licensed as an alcohol and drug abuse treatment program shall make application to the Division of Behavioral Health Services of the Department of Human Services on forms prescribed by the division and shall furnish the application information required by the division.

(2)(A) Each application for licensure shall be accompanied by a nonrefundable license fee of seventy-five dollars (\$75.00).

(B) An additional fee will be paid by the entity seeking licensure at the end of the licensure review process for costs of the licensure review.

**History.** Acts 1995, No. 173, §§ 5, 12; 2011, No. 228, § 3; 2013, No. 1107, § 33.

**Amendments.** The 2011 amendment rewrote the section heading; substituted “under former” for “pursuant to” in (a)(1); in (b)(1), substituted “office” for “bureau” twice, substituted “Office of Alcohol and Drug Abuse Prevention of the Division of Behavioral Health Services of the Department of Human Services” for “Bureau of

Alcohol and Drug Abuse Prevention,” and substituted “the application information” for “such information with the application as shall be.”

The 2013 amendment, in (b)(1), deleted “Office of Alcohol and Drug Abuse Prevention of the” following “application to the” and substituted “division” for “office” twice.

### 20-64-905. Renewal.

(a) Each alcohol and drug abuse treatment program licensure shall be renewed annually upon a payment of a fee of seventy-five dollars (\$75.00) by January 30 of each year to the Division of Behavioral Health Services.

(b) If any person or program covered by this subchapter fails to make application for renewal of his, her, or its license within one (1) year after expiration of the license, the license of the person or entity shall be revoked. That person or entity shall not be issued a new license, unless the person or entity makes application therefor and meets all requirements for licensure in effect at the time the application is filed.

**History.** Acts 1995, No. 173, § 8; 2013, No. 1107, § 34.

**Amendments.** The 2013 amendment

substituted “Division of Behavioral Health Services” for “Bureau of Alcohol and Drug Abuse Prevention” in (a).

**20-64-906. Disposition of funds.**

(a) All application fees and accreditation costs will be paid to the Division of Behavioral Health Services.

(b) The division shall transfer the money to the State Treasury, and the money shall be specially designated for transfer to the Public Health Fund to cover maintenance and operation expenses incurred by the accreditation review process.

**History.** Acts 1995, No. 1032, § 7; Health Services” for “Bureau of Alcohol and Drug Abuse Prevention” in (a); and 2013, No. 1107, § 35. substituted “division shall” for “bureau will” in (b).

**Amendments.** The 2013 amendment substituted the section as (a) and (b); substituted “Division of Behavioral

**20-64-907. Reporting requirements.**

(a) All persons, partnerships, associations, or corporations operating alcohol and drug abuse treatment programs in the State of Arkansas, whether licensed by the Division of Behavioral Health Services or expressly exempted from licensure, shall be required to furnish such information at such times and in such form as may be required by the division.

(b) The division shall promulgate regulations and prescribe forms for the implementation of this section.

**History.** Acts 1995, No. 173, § 10; Acts Health Services” for “Bureau of Alcohol and Drug Abuse Prevention” and “division” for “bureau”; and substituted “division” for “bureau” in (b). 2013, No. 1107, § 36.

**Amendments.** The 2013 amendment, in (a), substituted “Division of Behavioral

**20-64-908. Appeal process.**

(a) The Arkansas Alcohol and Drug Abuse Coordinating Council shall have the power and authority to hear appeals regarding decisions by the Division of Behavioral Health Services not to license an alcohol, drug, or alcohol and drug abuse treatment program under this subchapter.

(b) All hearings and proceedings under this section shall be conducted in accordance with the Arkansas Administrative Procedure Act, § 25-15-201 et seq.

**History.** Acts 1995, No. 173, § 11; substituted “Division of Behavioral Health Services” for “Bureau of Alcohol and Drug Abuse Prevention” in (a). 2013, No. 1107, § 37.

**Amendments.** The 2013 amendment

**20-64-910. Task Force on Substance Abuse Treatment Services.**

(a) There is created the “Task Force on Substance Abuse Treatment Services”.

(b) The task force shall be composed of the following members:



(1) Four (4) senators appointed by the President Pro Tempore of the Senate; and

(2) Four (4) members of the House of Representatives appointed by the Speaker of the House of Representatives.

(c) The task force shall also have sixteen (16) advisory members to be appointed as follows:

(1) Six (6) members recommended by the Arkansas Association of Substance Abuse Treatment Providers, Inc.;

(2) Two (2) members recommended by the Arkansas Association of Alcoholism and Drug Abuse Counselors;

(3) One (1) member recommended by the Arkansas Substance Abuse Certification Board;

(4) One (1) member recommended by the State Board of Examiners of Alcoholism and Drug Abuse Counselors;

(5) One (1) member recommended by the Arkansas Alcohol and Drug Abuse Coordinating Council;

(6) One (1) member recommended by the Division of Behavioral Health Services;

(7) Two (2) members appointed by the President Pro Tempore of the Senate; and

(8) Two (2) members appointed by the Speaker of the House of Representatives.

(d)(1) The terms of the legislative members of the task force shall expire on December 31 of each even-numbered year.

(2) Advisory members shall serve at the pleasure of the organizations they represent.

(e) Vacancies on the task force shall be filled in the same manner as provided for the initial appointment.

(f) The chair shall be one (1) of the legislative members of the task force and shall be selected by the legislative members of the task force.

(g)(1) The task force shall meet as often as is deemed necessary by the chair.

(2) The chair shall call the first meeting, which shall be held no later than sixty (60) days after July 16, 2003.

(h)(1) Legislative members of the task force shall be entitled to per diem and mileage at the same rate authorized by law for attendance at meetings of interim committees of the General Assembly.

(2) Advisory members of the task force shall serve without compensation and shall not receive per diem, mileage, or stipends.

(i) The task force shall receive staff support from the Bureau of Legislative Research.

**History.** Acts 2003, No. 1457, § 1; 2005, No. 64, § 1; 2007, No. 688, § 1; 2009, No. 471, § 1; 2013, No. 1107, § 38.

**A.C.R.C. Notes.** References to “this subchapter” in §§ 20-64-901 through 20-64-909 may not apply to this section, which was enacted subsequently.

**Amendments.** The 2009 amendment substituted “Alcohol” for “Alcoholism” in (c)(5); and rewrote (h).

The 2013 amendment substituted “Division of Behavioral Health Services” for “Office of Alcohol and Drug Abuse Prevention” in (c)(6).



**20-64-911. Purpose.**

(a) The purpose of the Task Force on Substance Abuse Treatment Services is to assess statewide delivery of substance abuse treatment services.

(b) The task force will strive to achieve the following:

(1) To assess state substance abuse treatment needs and evaluate the current service delivery system and its capacity to respond to those current and projected treatment needs;

(2) To examine state interagency referral trends and continuity of care to include the identification of service duplication and service overlap;

(3) To determine accurate statewide service costs and identify more cost-effective means for the delivery of substance abuse treatment services and the identification of available revenue streams, underutilized revenue, and uncaptured revenue;

(4) To carry out a cost-benefit analysis of substance abuse treatment services to include outcome benefits for the development of policy and procedure reform; and

(5) To make recommendations for the strategic development and implementation of efficient and effective quality care measures.

(c)(1) The findings and recommendations of the task force shall be submitted to the legislative leaders, state department directors, state providers, and other appropriate parties for collaborative reform.

(2)(A) The task force shall report to the Legislative Council, the Senate Committee on Public Health, Welfare, and Labor, and the House Committee on Public Health, Welfare, and Labor.

(B) The report shall be submitted no later than October 1 of each even-numbered year.

**History.** Acts 2003, No. 1457, § 2; 2013, No. 1132, § 39.

which was enacted subsequently.

**A.C.R.C. Notes.** References to “this subchapter” in §§ 20-64-901 through 20-64-909 may not apply to this section,

**Amendments.** The 2013 amendment deleted “Interim” twice following “Senate” and “House” in (c)(2)(A).

**SUBCHAPTER 10 — ALCOHOL AND DRUG ABUSE COORDINATING COUNCIL**

SECTION.	SECTION.
20-64-1001. Arkansas Drug Director.	20-64-1003. Arkansas Alcohol and Drug Abuse Coordinating Council — Functions, powers, and duties.
20-64-1002. Arkansas Alcohol and Drug Abuse Coordinating Council — Creation.	

**20-64-1001. Arkansas Drug Director.**

(a)(1) There is created within the Office of the Governor a position of Arkansas Drug Director, who shall serve at the pleasure of the Governor.

(2) Effective at 12:01 a.m. on July 1, 2005, the position of Arkansas Drug Director is transferred to the Division of Behavioral Health Services.

(b) The Arkansas Drug Director shall serve as the coordinator for development of an organizational framework to ensure that alcohol and drug programs and policies are well planned and coordinated.

(c) The Arkansas Drug Director, in cooperation with the Department of Finance and Administration, shall perform financial monitoring of each drug task force of the state to ensure that grant funds are being expended according to law and to ensure that the drug task force's financial record system is adequate to provide a clear, timely, and accurate accounting of all asset forfeitures, revenues, and expenditures.

(d)(1) The Arkansas Drug Director shall maintain an office at a location to be determined by the Director of the Division of Behavioral Health Services. All records required by law to be kept by the director shall be maintained at the office.

(2) The Arkansas Drug Director is authorized to establish and enforce rules and regulations regarding the management of the Special State Assets Forfeiture Fund, created in § 19-5-972, and the maintenance and inspection of drug task force records concerning asset forfeitures, revenues, expenditures, and grant funds.

(3) The Director of the Division of Behavioral Health Services is authorized to hire employees to assist in these functions.

**History.** Acts 1989, No. 855, § 1; 2001, No. 1690, § 3; 2005, No. 1954, § 6.

## **20-64-1002. Arkansas Alcohol and Drug Abuse Coordinating Council — Creation.**

(a) There is hereby established the Arkansas Alcohol and Drug Abuse Coordinating Council, hereafter referred to in this subchapter as the coordinating council.

(b) The coordinating council shall be composed of twenty-seven (27) members as follows:

(1) Thirteen (13) members of the coordinating council shall be administrative officers of the following agencies, or their appropriate designees, confirmed by gubernatorial appointment:

(A) The Arkansas Drug Director, who shall serve as chair of the coordinating council;

(B) The Director of the Division of Behavioral Health Services;

(C) The Director of the Department of Arkansas State Police;

(D) The Commissioner of Education;

(E) The Director of the Arkansas State Highway and Transportation Department;

(F) The Director of the Department of Correction;

(G) The Director of the Department of Finance and Administration;

(H) The Adjutant General of the Arkansas National Guard;



- (I) The Attorney General of Arkansas;
  - (J) The Director of the State Crime Laboratory;
  - (K) The Director of the Office of Alcohol Testing of the Department of Health;
  - (L) The Director of the Administrative Office of the Courts; and
  - (M) The Director of the Department of Community Correction.
- (2) The following persons shall be appointed by the Governor for three-year terms and will not serve more than two (2) consecutive terms:
- (A) One (1) police chief, one (1) county sheriff, and one (1) drug court judge;
  - (B) A prosecuting attorney;
  - (C) A private citizen not employed by the state or federal government;
  - (D) A director of a publicly funded alcohol and drug abuse treatment program;
  - (E) A school drug counselor;
  - (F) A director of a drug abuse prevention program;
  - (G) A director of a driving while intoxicated program;
  - (H) A health professional; and
  - (I) Four (4) members from the state at large who have demonstrated knowledge of or interest in alcohol and drug abuse prevention, at least two (2) of whom shall be recovering persons.
- (c) The coordinating council members may receive expense reimbursement and stipends in accordance with § 25-16-901 et seq.
- (d) The coordinating council may appoint noncouncil members for PEER review of grants, and the PEER Review Committee members shall be entitled to reimbursement for actual expenses and mileage to be paid by the Division of Behavioral Health Services from funds appropriated for its maintenance and operation.
- (e) The United States Attorney for Arkansas or his or her designee shall serve on the council in an advisory capacity.

**History.** Acts 1989, No. 855, §§ 2, 5; substituted "Division of Behavioral Health Services" for "Office of Alcohol and Drug Abuse Prevention" in (b)(1)(B) and (d).  
1995, No. 551, § 1; 1997, No. 250, § 203;  
2005, No. 1453, § 1; 2013, No. 1107,  
§§ 39, 40.

**Amendments.** The 2013 amendment

### **20-64-1003. Arkansas Alcohol and Drug Abuse Coordinating Council — Functions, powers, and duties.**

- (a) The Arkansas Alcohol and Drug Abuse Coordinating Council shall have the responsibility for overseeing all planning, budgeting, and implementation of expenditures of state and federal funds allocated for alcohol and drug education, prevention, treatment, and law enforcement.
- (b) The coordinating council shall have the following functions, powers, and duties:



(1) All federal money received by the State of Arkansas for drug law enforcement, education, or prevention shall be reviewed by the coordinating council for disbursement, accountability, and evaluation;

(2) The coordinating council shall review and coordinate all school-based drug education, prevention, and awareness programs and efforts funded by the state.

(c) The coordinating council shall assist community-based prevention councils in planning and coordinating prevention activities, promoting innovative programs, developing stable funding sources, and disseminating current information. These local councils should be racially balanced and shall include at least one (1) representative from each of the following groups:

- (1) One (1) law enforcement officer;
- (2) One (1) school board member;
- (3) One (1) school administrator;
- (4) One (1) school teacher;
- (5) One (1) parent;
- (6) One (1) student;
- (7) One (1) alcohol and drug abuse program director; and
- (8) One (1) health professional.

(d) The coordinating council shall develop training and education programs for criminal justice personnel in drug-related matters in conjunction with the Arkansas Law Enforcement Training Academy.

(e)(1) The coordinating council shall have authority to develop its rules of procedure to include the establishment of a committee structure for the approval of funding and other purposes.

(2) Committees shall include, but not be limited to, a prevention, education, and treatment committee chaired by the Director of the Division of Behavioral Health Services, and a law enforcement committee.

(f) The coordinating council shall establish advocacy groups among the business community and youth population of this state.

(g) The coordinating council shall work with all federal, state, county, and local law enforcement agencies to ensure an integrated system of enforcement activities.

(h) The coordinating council shall perform other functions as may be necessary to carry out the functions, powers, and duties as set forth in this subchapter.

**History.** Acts 1989, No. 855, §§ 3, 4; 1995, No. 551, §§ 2, 3; 2013, No. 1107, § 41.

**Amendments.** The 2013 amendment

substituted "Division of Behavioral Health Services" for "Bureau of Alcohol and Drug Abuse Prevention" in (e)(2).

**SUBCHAPTER 11 — TASK FORCE ON SUBSTANCE ABUSE PREVENTION**

## SECTION.

20-64-1101. Findings — Purpose.  
20-64-1102. Task Force on Substance Abuse Prevention — Creation.

## SECTION.

20-64-1103. Task Force on Substance Abuse Prevention — Duties.

**20-64-1101. Findings — Purpose.**

(a) The General Assembly finds:

(1) There is a great need to develop and recommend long-range alternative means for reducing the ever-growing and costly demands on the substance abuse treatment and criminal justice systems in the State of Arkansas;

(2) Research models have demonstrated that the prevention of early initiation into alcohol and drug use and other risky behaviors requires a sustained community-wide effort;

(3) Community-wide substance abuse prevention efforts must target the life spectrum and must include efforts to curb the misuse of common household products, over-the-counter medications, prescription medicines, alcohol, and illegal substances;

(4) To date, very few state resources have been invested to prevent one of the most ubiquitous and costly issues confronting our state, that is, substance abuse;

(5) Most substance abuse prevention efforts within Arkansas have been at the mercy of the federal government rather than at the direction of the state; and

(6) Consequently, as federal resources wane, so do substance abuse prevention efforts throughout this state.

(b) The purpose of this subchapter is the improvement of substance abuse prevention programs in the state.

**History.** Acts 2007, No. 629, § 1.

**20-64-1102. Task Force on Substance Abuse Prevention — Creation.**

(a) The Task Force on Substance Abuse Prevention is created.

(b) The task force shall be composed of the following twenty-one (21) members:

(1) Two (2) senators appointed by the President Pro Tempore of the Senate;

(2) Two (2) members of the House of Representatives appointed by the Speaker of the House of Representatives;

(3) One (1) member recommended by the Arkansas Prevention Certification Board;

(4) Three (3) members recommended by the Division of Behavioral Health Services, to include one (1) member representative of substance abuse prevention providers;

(5) One (1) member recommended by the Regional Prevention Resource Centers;

(6) Two (2) members recommended by the Arkansas Prevention Network;

(7) Two (2) members recommended by the Department of Education-Safe and Drug Free Schools Program, to include one (1) member who is a Department of Education-Safe and Drug Free Schools Program state-level coordinator and one (1) member who is a Department of Education-Safe and Drug Free Schools Program coordinator of a local education agency;

(8) One (1) member recommended by the Arkansas Collegiate Drug Education Committee;

(9) One (1) member recommended by the Arkansas regional office of Mothers Against Drunk Driving;

(10) One (1) member recommended by the University of Arkansas at Little Rock MidSOUTH Prevention Institute;

(11) One (1) member recommended by the Hometown Health Improvement Office of the Department of Health;

(12) One (1) member recommended by the Arkansas Child Abuse/Rape/Domestic Violence Commission;

(13) One (1) member recommended by the College of Health and Behavioral Sciences of the University of Central Arkansas;

(14) One (1) member recommended by the Arkansas Drug Director; and

(15) One (1) member recommended by the Office of Head Start of the Department of Human Services.

(c) The terms of the legislative members of the task force shall expire on December 31 of each even-numbered year.

(d) Nonlegislative members shall serve at the pleasure of the organizations they represent.

(e) Vacancies on the task force shall be filled in the same manner as provided for the initial appointment.

(f) The chair shall be one (1) of the legislative members of the task force and shall be selected by the legislative members of the task force.

(g) The task force shall meet as often as is deemed necessary by the chair.

(h) The chair shall call the first meeting, which shall be held no later than sixty (60) days after July 31, 2007.

(i) The members of the task force shall serve without compensation and shall not receive per diem, mileage, or stipends.

(j) The task force shall receive staff support from the Bureau of Legislative Research.

**History.** Acts 2007, No. 629, § 1; 2013, No. 1107, § 42.

substituted "Division of Behavioral Health Services" for "Office of Alcohol and Drug Abuse Prevention" in (b)(4).

**Amendments.** The 2013 amendment



**20-64-1103. Task Force on Substance Abuse Prevention — Duties.**

(a) The Task Force on Substance Abuse Prevention shall:

(1) Evaluate the current substance abuse prevention service delivery system and its capacity to respond to current and projected prevention needs across the full life spectrum, from the prenatal state and early childhood development through adolescence and until the conclusion of adult life;

(2) Assess the degree of community awareness across the state of the value of effective evidence-based substance abuse prevention;

(3) Assess financial resources available to invest in substance abuse prevention programs and to identify all available revenue streams, including underutilized revenue and uncaptured revenue;

(4) Identify all active substance abuse prevention programs in each county throughout the state and determine the specific areas of the state where prevention programs are inadequate or absent; and

(5) Make recommendations designed to improve and increase sustainable substance abuse prevention services throughout the state, including identifying of methods to enhance the development and support of effective community-based programs.

(b) The task force shall submit an annual report to the Legislative Council, the Senate Committee on Public Health, Welfare, and Labor, and the House Committee on Public Health, Welfare, and Labor no later than October 1 of each year.

**History.** Acts 2007, No. 629, § 1; 2013, No. 1132, § 40.

**A.C.R.C. Notes.** Acts 2007, No. 629, § 2, provided:

“(a) The initial findings and recommendations of the task force shall be circulated for review and comment to legislators, affected state agency directors, state substance abuse prevention providers, and other appropriate parties desiring collaborative reform of substance abuse pre-

vention programs.

“(b) The task force shall submit the final report to the Legislative Council, the Senate Interim Committee on Public Health, Welfare, and Labor, and the House Interim Committee on Public Health, Welfare, and Labor.”

**Amendments.** The 2013 amendment deleted “Interim” twice following “Senate” and “House” in (b).

***SUBTITLE 5. SOCIAL SERVICES***

**CHAPTER 76**

**PUBLIC ASSISTANCE GENERALLY**

SUBCHAPTER.

1. GENERAL PROVISIONS.
  2. ADMINISTRATION GENERALLY.
  4. GRANTS OF ASSISTANCE.
  5. ARKANSAS RX PROGRAM.
  6. COMMUNITY SERVICES OVERSIGHT AND PLANNING COUNCIL.
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**A.C.R.C. Notes.** Acts 2011, No. 937, § 26, provided: "TANF STUDY. The Department of Workforce Services shall immediately proceed with issuing a Request for Proposals (RFP), or other appropriate methodology, requesting qualified vendors to submit proposals for the completion of a study to determine the best and most appropriate way to address the financial needs of grandparents raising grandchildren through the Temporary Assistance for Needy Families (TANF) Block Grant Program. Immediately upon receiving responses from qualified vendors, the Department shall immediately take steps to enter into a contract arrangement with the vendor that submits the lowest and/or most responsible response to the RFP and begin the study. The contract shall be awarded no later than June 30, 2011.

"Questions to be addressed in the study shall include, but not be limited to:

"1) What program model is best for Arkansas?

"2) Which children will be eligible?

"3) Should payments be limited to relatives with legal guardianship, unrelated foster parents, or unrelated individuals with close ties to the child or family?

"4) What impact will these payments have on other public benefits currently received on behalf of these children?

"5) What agency will determine eligibility?

"6) What about child support obligations?

"7) Who will regulate residence compliance?

"8) Will the program require criminal background checks? If yes, who will pay for it?

"9) What is the actual financial impact for the TANF program?

"10) What other funding sources exists for the proposed program?

"The Department shall consider the findings of this study in conjunction with the Department's TANF Program Independent Evaluation Study and the evaluation of the Arkansas Career Pathways Initiative. In addition, the Department shall duly consider the findings from the grandparents raising grandchildren study as they prepare their annual TANF budget.

"If the Department of Workforce Services fails to comply with all of the provisions of this Section by December 31,

2011, the Department shall immediately begin providing cash assistance payments to grandparents who are the legal guardians of their grandchildren, and whose incomes are below 100% of the Federal Poverty Level (FPL). These payments shall be paid at the rate of \$100 per month per grandparent household."

Acts 2012, No. 282, § 26, provided: "TANF STUDY. The Department of Workforce Services shall immediately proceed with issuing a Request for Proposals (RFP), or other appropriate methodology, requesting qualified vendors to submit proposals for the completion of a study to determine the best and most appropriate way to address the financial needs of grandparents raising grandchildren through the Temporary Assistance for Needy Families (TANF) Block Grant Program. Immediately upon receiving responses from qualified vendors, the Department shall immediately take steps to enter into a contract arrangement with the vendor that submits the lowest and/or most responsible response to the RFP and begin the study. The contract shall be awarded no later than June 30, 2011.

"Questions to be addressed in the study shall include, but not be limited to:

"1) What program model is best for Arkansas?

"2) Which children will be eligible?

"3) Should payments be limited to relatives with legal guardianship, unrelated foster parents, or unrelated individuals with close ties to the child or family?

"4) What impact will these payments have on other public benefits currently received on behalf of these children?

"5) What agency will determine eligibility?

"6) What about child support obligations?

"7) Who will regulate residence compliance?

"8) Will the program require criminal background checks? If yes, who will pay for it?

"9) What is the actual financial impact for the TANF program?

"10) What other funding sources exists for the proposed program?

"The Department shall consider the findings of this study in conjunction with the Department's TANF Program Independent Evaluation Study and the evaluation of the Arkansas Career Pathways



Initiative. In addition, the Department shall duly consider the findings from the grandparents raising grandchildren study as they prepare their annual TANF budget.

"If the Department of Workforce Services fails to comply with all of the provisions of this Section by December 31, 2011, the Department shall immediately begin providing cash assistance payments to grandparents who are the legal guardians of their grandchildren, and whose incomes are below 100% of the Federal Poverty Level (FPL). These payments shall be paid at the rate of \$100 per month per grandparent household."

Acts 2013, No. 535, § 1, provided:

"(a) The General Assembly finds that:

"(1) Public benefit programs currently restrict eligibility to individuals and families with few or no resources or assets to ensure that public resources are accurately allocated to those most in need;

"(2) Resource or asset limits discourage savings and deter families from making investments, potentially increasing the duration that a family is reliant on public benefits;

"(3) In theory, resource or asset limits cause public benefits to be denied to families who are only marginally more financially secure than those families that do qualify;

"(4) The current resource or asset limit is two thousand dollars (\$2,000) for the Supplemental Nutrition Assistance Program (SNAP) and three thousand dollars (\$3,000) for the Temporary Assistance for Needy Families (TANF);

"(5) The state has discretion to change or eliminate the resource or asset limits for these and other programs administered by the Department of Human Services; and

"(6) To be prudent with our limited public resources, a study should be conducted to analyze the potential effects of changing or eliminating the resource or asset limits on the SNAP and TANF programs.

"(b)(1) The department shall conduct a study on the effectiveness, consistency, and efficiency of the SNAP and TANF public benefit programs and program administration, including the impact of changing or eliminating resource or asset limits.

"(2) The study shall include without limitation:

"(A) The number of applicants for SNAP and TANF that were denied based on resource or asset limits;

"(B) The cost associated with verifying resource or asset limits, including staff time and department resources;

"(C) The cost implications of changing or eliminating the resource or asset limits;

"(D) A review of practices, policies, and trends regarding resource and asset limits in other states, including how they apply to the SNAP and TANF programs; and

"(E) An analysis of other public benefit programs that no longer have resource or asset limits.

"(3) The department shall submit a report to the General Assembly no later than November 1, 2013, that contains information learned from the study and findings and recommendations of the department as a result of the study."

## SUBCHAPTER 1 — GENERAL PROVISIONS

### SECTION.

20-76-101. Definitions.

20-76-102. Coordination of state agency service delivery.

20-76-103. [Repealed.]

20-76-105. Temporary Assistance for Needy Families Oversight Board.

20-76-106. Statewide implementation plan — Transitional Employment Assistance.

20-76-107. [Repealed.]

### SECTION.

20-76-108. [Repealed.]

20-76-109. Use of contracts.

20-76-110, 20-76-111. [Repealed.]

20-76-112. Human Services Workers in the Schools Program.

20-76-113. Promoting outcomes for the Transitional Employment Assistance Program and the Arkansas Work Pays Program.



**Effective Dates.** Acts 2003, No. 1306, § 7: July 1, 2003. Emergency clause provided: "It is found and determined by the General Assembly of the State of Arkansas that it is crucial to the life and health of many needy citizens of the State of Arkansas that the outcomes of the transitional employment program are more clearly defined and monitored in order that these public assistance programs can be better focused on meeting the real needs of needy Arkansans, that the United States Congress is in the process of reauthorizing the federal laws which guide and fund these programs, and that it is necessary, in order to avoid any disruption in federal funding, that the program outcomes be clearly defined so as to provide better information to the federal government about the progress of these programs in Arkansas. Therefore, an emergency is declared to exist and this act being necessary for the preservation of the public peace, health, and safety shall become effective on July 1, 2003."

Acts 2005, No. 1705, § 20: Effective date clause provided:

"(a) Section 10 of this act shall become effective immediately upon enactment.

"(b) Sections 3, 6, 7, 9, 11, 12 and 14 through 18 shall become effective upon certification from the Directors of the Employment Security Department and the Department of Human Services with consent from the Governor and the Chair of the Senate Committee on Public Health, Welfare and Labor and the Chair of the House Committee on Public Health, Welfare and Labor.

"(c)(1) Section 19 shall become effective on January 1, 2006.

"(2) Within Section 19 of this act:

"(A) The effective date for the Arkansas Work Pays Program, Arkansas Code § 20-76-444, may be delayed up to July 1, 2006 if the Transitional Employment Board certifies to the Governor that the transfer of Transitional Employment Assistance Program will not take place until January 1, 2006 or later and that it is in the public interest that the effective date of Work Pays be delayed.

"(B) Arkansas Code § 20-76-445 shall become effective July 1, 2005.

"(C) Arkansas Code § 20-76-446 shall become effective on January 1, 2006."

Acts 2005, No. 1705, § 21: July 1, 2005. Emergency clause provided: "It is found

and determined by the General Assembly of the State of Arkansas that due to increasing requirements in the Transitional Employment Assistance Program amendments made in sections 4, 5, 8, 12, and 13 of this act are necessary for continued effectiveness of the program and provision of services to families. Therefore, an emergency is declared to exist and this act being necessary for the preservation of the public peace, health, and safety, section 10 will be in full force and effect immediately and sections 4, 5, 8, and 13 shall be in full force and effect on and after July 1, 2005."

Acts 2005, No. 1705 was signed by the Governor on April 5, 2005.

Acts 2007, No. 514, § 25: Mar. 27, 2007. Emergency clause provided: "It is found and determined by the General Assembly of the State of Arkansas that the state fiscal year begins July 1, 2007; that the state agencies responsible for the programs under this act require time to prepare for the program changes created in this act; that families in need of temporary assistance may not receive the needed assistance if this act does not become effective immediately; and that any delay in the effective date of this act could work irreparable harm on families in need of temporary assistance. Therefore, an emergency is declared to exist and this act being necessary for the preservation of the public peace, health, and safety shall become effective on: (1) The date of its approval by the Governor; (2) If the bill is neither approved nor vetoed by the Governor, the expiration of the period of time during which the Governor may veto the bill; or (3) If the bill is vetoed by the Governor and the veto is overridden, the date the last house overrides the veto."

Acts 2007, No. 1050, § 2: Apr. 15, 2007. Emergency clause provided: "It is found and determined by the General Assembly of the State of Arkansas that there is a need for a human services workers program in schools and that this act is immediately necessary because most schools lack the expertise to provide appropriate services to students and because there is a need to inform schools about the availability of the program prior to the end of the current school year to have the opportunity to recruit a sufficient number of human services workers for the next school year. Therefore, an emergency is declared to exist and this act being necessary for

the preservation of the public peace, health, and safety shall become effective on April 15, 2007.”

Acts 2011, No. 1228, § 2: Apr. 15, 2011. Emergency clause provided: “It is found and determined by the General Assembly of the State of Arkansas that there is a need for a human services workers program in schools and that this act is immediately necessary because most schools lack the expertise to provide appropriate

services to students and because there is a need to inform schools about the availability of the program prior to the end of the current school year to have the opportunity to recruit a sufficient number of human services workers for the next school year. Therefore, an emergency is declared to exist, and this act being necessary for the preservation of the public peace, health, and safety shall become effective on April 15, 2011.”

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## 20-76-101. Definitions.

As used in this chapter:

(1) “Assessment services” means an evaluation to determine the abilities, talents, proficiencies, and deficiencies of applicants and recipients with regard to the ability of the individual to move into employment;

(2) “Board” means the Temporary Assistance for Needy Families Oversight Board;

(3) “Date of enrollment” means the date that an applicant is approved as eligible for the Transitional Employment Assistance Program;

(4) “Department” means the Department of Human Services;

(5) “Diversion from assistance” means a one-time loan of money or the furnishing of nonmonetary assistance to an applicant who is eligible for but does not require enrollment in the program;

(6) “Education or training” means basic remedial education, adult education, high school education, education to obtain the equivalent of a high school diploma, education to learn English as a second language, applied technology training, and postsecondary education and training;

(7) “Employment assistance” means financial assistance, child care, assistance to secure full-time employment, assistance in obtaining education and training that leads to full-time employment, case management services, and other services designed to assist recipients in achieving self-sufficiency through employment;

(8) “Extended support services” means assistance to a recipient who has obtained employment under the program, which may include, but is not limited to, child care and medical assistance;

(9) “Full-time education or training” means education or training on a full-time basis as defined by the department;

(10) “Medical assistance” means assistance furnished pursuant to Title XIX of the Social Security Act, commonly referred to as Medicaid, or a state-funded medical assistance program;

(11) “Personal responsibility agreement” means an agreement between the department and the recipient specifying the recipient’s responsibilities that are a condition of receiving employment assistance, which may include an employment plan that describes what the



recipient and the department will do to assist the recipient in achieving self-sufficiency through employment;

(12) "Positive reinforcement outcome bonus" means a one-time cash assistance bonus for achieving an employment plan goal;

(13) "Relocation assistance" means assistance to an eligible recipient who lives in an area of limited job opportunities to enable the recipient to relocate for purposes of full-time employment that the recipient has secured;

(14) "Support services" means child care, transportation, financial assistance, medical assistance, substance abuse treatment, life skills training, parenting skills training, and other similar assistance;

(15) "TEA" means the Transitional Employment Assistance Program;

(16) "Temporary Assistance for Needy Families Program" means all Arkansas programs funded by federal Temporary Assistance to Needy Families block grant funds or state funds claimed as maintenance of effort under the federal Temporary Assistance for Needy Families program, including:

(A) The Transitional Employment Assistance Program;

(B) The Arkansas Work Pays Program;

(C) The Career Pathways Initiative; and

(D) The Community Investment Initiative; and

(17) "Unearned income" means all income that a recipient receives from sources other than employment, including child support payments, supplemental security income, supplemental security disability income, workers' compensation, and unemployment insurance.

**History.** Acts 1939, No. 280, § 1; 1953, 1997, No. 1058, § 2; 1999, No. 1567, § 3; No. 110, § 1; A.S.A. 1947, § 83-101; Acts 2007, No. 514, § 1.

## **20-76-102. Coordination of state agency service delivery.**

(a) To ensure that all available state government resources are used to help transitional employment assistance recipients make the transition from welfare to work, each of the following state agencies and organizations shall also be required to work with the Department of Workforce Services in providing transitional employment assistance services:

(1) The Department of Human Services;

(2) The Department of Higher Education, including community colleges and the University of Arkansas Cooperative Extension Service;

(3) The Department of Education;

(4) The Arkansas Development Finance Authority;

(5) The Arkansas Economic Development Council;

(6) The Arkansas State Highway and Transportation Department;

(7) The Department of Finance and Administration, including the Office of Child Support Enforcement;

(8) The State Child Abuse and Neglect Prevention Board;

(9) The Arkansas Literacy Councils, Inc.;

(10) The Department of Career Education; and

(11) Other state agencies as directed by the Governor or as directed by the General Assembly.

(b) State agencies required under subsection (a) of this section to work with the Department of Workforce Services in providing transitional employment assistance services to recipients shall make every effort to use financial resources in their respective budgets and to seek additional funding sources, whether private or federal, to supplement the moneys allocated by the Department of Workforce Services for the Transitional Employment Assistance Program.

(c) All agencies of the state and local governments providing program services shall work cooperatively with and provide any necessary assistance to the General Assembly and the Temporary Assistance for Needy Families Oversight Board and shall furnish, in a timely manner, complete and accurate information regarding the program to legislative committees and the board upon request.

**History.** Acts 1987, No. 184, §§ 14, 15; 1997, No. 1058, § 3; 1999, No. 1567, §§ 4, 5; 2005, No. 1705, § 3; 2007, No. 514, § 1.

**A.C.R.C. Notes.** Acts 2005, No. 1705, § 20(b), provided: "Sections 3, 6, 7, 9, 11, 12 and 14 through 18 shall become effective upon certification from the Directors

of the Employment Security Department and the Department of Human Services with consent from the Governor and the Chair of the Senate Committee on Public Health, Welfare and Labor and the Chair of the House Committee on Public Health, Welfare and Labor."

### 20-76-103. [Repealed.]

**Publisher's Notes.** This section, concerning use of subpoenas in hearings on benefit determinations, was repealed by

Acts 2011, No. 1139, § 4. The section was derived from Acts 1987, No. 727, §§ 1-5; 1993, No. 273, § 1.

### 20-76-105. Temporary Assistance for Needy Families Oversight Board.

(a) The Temporary Assistance for Needy Families Oversight Board is created.

(b) The board shall be composed of the following members:

(1) The Director of the Department of Workforce Services;

(2) The Director of the Arkansas Workforce Investment Board;

(3) The Director of the Division of County Operations of the Department of Human Services;

(4)(A) Four (4) members appointed by the Governor.

(B) One (1) member appointed under subdivision (b)(4)(A) of this section shall be a current or former recipient of transitional employment assistance or Aid to Families with Dependent Children;

(5) One (1) member appointed by the Speaker of the House of Representatives; and

(6) One (1) member appointed by the President Pro Tempore of the Senate.



(c)(1) The board is designed to be an agent of change and challenge to the existing federal, state, and local agency service delivery mechanisms for programs serving low-income parents.

(2) The challenge shall be to ensure that persons in the Temporary Assistance for Needy Families Program are getting the assistance, the information, and the services needed to help these low-income persons become self-sufficient.

(3) The chair and the appointed members of the board shall be selected on the basis of their:

(A) Experience and knowledge in administering and overseeing public assistance and work programs; and

(B) Understanding and commitment to active oversight of these programs.

(d) The appointed members of the board shall serve four-year terms.

(e) The Governor shall appoint the Chair of the Temporary Assistance for Needy Families Oversight Board from among the appointed members.

(f) Five (5) members including at least three (3) appointed members of the board shall constitute a quorum.

(g) The board shall meet as often as necessary to complete its statutory responsibilities, but no less than one (1) time every three (3) months.

(h) The Governor may remove an appointed member for cause.

(i) Vacancies on the board shall be filled in the same manner as the original appointment for the unexpired portion of the term.

(j)(1) The Director of the Department of Workforce Services shall designate a senior manager of the Department of Workforce Services as staff director for the board.

(2) Additional staff support to the board shall be provided by the Department of Workforce Services and the Department of Human Services.

(k) The responsibilities of the board include:

(1)(A) Developing a vision and blueprint for the Temporary Assistance for Needy Families Program to:

(i) Provide effective services to the Transitional Employment Assistance Program and Arkansas Work Pays Program clients;

(ii) Improve performance on the Transitional Employment Assistance Program client outcomes; and

(iii) Integrate Transitional Employment Assistance Program services, Arkansas Work Pays Program services, and services offered in local workforce offices.

(B) The board shall submit its recommended vision and blueprint to the Governor and the House Committee on Public Health, Welfare, and Labor and the Senate Committee on Public Health, Welfare, and Labor no later than December 31, 2007;

(2) Reviewing and developing recommendations to the Governor, the General Assembly, the Department of Workforce Services, and other state agencies on the following topics:

(A) Budget planning and the use of state and federal Temporary Assistance for Needy Families Program funds;

(B) Measurement and performance on the Transitional Employment Assistance Program outcomes;

(C) Performance management of the operation of the Temporary Assistance for Needy Families Program;

(D) Administrative operations, including without limitation:

(i) Dividing responsibilities among participating agencies;

(ii) Information systems; and

(iii) The integration of Transitional Employment Assistance and workforce systems;

(E) Rules developed by the Department of Workforce Services and other state agencies dealing with the Transitional Employment Assistance Program, the Arkansas Work Pays Program, the Arkansas Career Pathways Initiative, the Community Investment Initiative, and other initiatives within the Temporary Assistance for Needy Families Program;

(F) Policy and administration of the Transitional Employment Assistance Program, the Arkansas Work Pays Program, the Career Pathways Initiative, the Community Investment Initiative, and other initiatives within the Temporary Assistance for Needy Families Program; and

(G) Additional initiatives that may be included within the Temporary Assistance for Needy Families Program or funded with Temporary Assistance for Needy Families Program funds;

(3) Determining the scope of work and timeline for the independent evaluation of the Temporary Assistance for Needy Families Program;

(4) Making reports to the Governor and to the House Committee on Public Health, Welfare, and Labor and the Senate Committee on Public Health, Welfare, and Labor on the operations of the Transitional Employment Assistance Program, the Arkansas Work Pays Program, the Career Pathways Initiative, the Community Investment Initiative, and other Temporary Assistance for Needy Families initiatives; and

(5) Other responsibilities determined by a majority of the board.

**History.** Acts 1997, No. 1058, § 4; 1999, No. 1567, § 6; 2001, No. 1264, §§ 1-3; 2003, No. 1306, §§ 1-3; 2005, No. 1705, §§ 4-6; 2007, No. 514, § 2; 2009, No. 952, § 11; 2013, No. 1132, § 41.

**A.C.R.C. Notes.** Acts 2005, No. 1705, § 20(b), provided: "Sections 3, 6, 7, 9, 11, 12 and 14 through 18 shall become effective upon certification from the Directors of the Employment Security Department and the Department of Human Services with consent from the Governor and the

Chair of the Senate Committee on Public Health, Welfare and Labor and the Chair of the House Committee on Public Health, Welfare and Labor."

**Amendments.** The 2009 amendment substituted "One (1) member" for "Two (2) members, one (1) to be" in (b)(5), and made minor stylistic changes in (b)(4)(A) and (6).

The 2013 amendment deleted "Interim" twice following "House" and "Senate" in (k)(1)(B).



**RESEARCH REFERENCES**

**U. Ark. Little Rock L. Rev.** Survey of Legislative, 2003 Arkansas General Assembly, Public Health and Welfare, Transitional Employment Assistance Program, 26 U. Ark. Little Rock L. Rev. 466.

**20-76-106. Statewide implementation plan — Transitional Employment Assistance.**

(a) The Department of Workforce Services shall:

(1) Develop a statewide implementation plan for ensuring the cooperation of state agencies and local agencies and encouraging the cooperation of private entities, especially those receiving state funds, in the coordination and implementation of the Transitional Employment Assistance Program, the Arkansas Work Pays Program, and achievement of the goals; and

(2)(A) Ensure that program recipients throughout the state, including those in rural areas, have comparable access to transitional employment assistance benefits.

(B) The statewide implementation plan shall be subject to the review and recommendation of the board.

(b) At a minimum, the transitional employment assistance implementation plan shall include:

(1) Performance standards and measurement criteria for state and county offices of the Department of Human Services, the Department of Workforce Services, and all service providers under the program;

(2) Contract guidelines for contract service providers under the program;

(3) Guidelines for training transitional employment assistance service providers, whether state employees or contract providers;

(4) Functions to be performed by each state agency in helping recipients make the transition from welfare to work;

(5) Guidelines for clarifying or, if necessary, modifying the rules of the state agencies charged with implementing the program so that all unnecessary duplication is eliminated;

(6) Guidelines for modifying compensation and incentive programs for state employees in order to achieve the performance outcomes necessary for successful implementation of the program;

(7) Guidelines for timely assessments for each participant which lead to an individual personal responsibility agreement that identifies the strengths of the participant and the barriers faced in obtaining a job and reaching self-sufficiency and the services to be provided to assist the participant in finding and keeping work and in moving toward self-sufficiency;

(8) Guidelines for timely provision of needed support services as specified in the individual personal responsibility agreement. These guidelines shall include procedures for evaluating the quality and value of assessments and the provision of support services;

(9) Guidelines governing job search requirements for transitional employment assistance applicants;

(10) Guidelines governing the provision of support services to transitional employment assistance participants and former transitional employment assistance participants to assist them in retaining employment and earning higher wages and career advancement;

(11) Guidelines governing the combining of work with education and training;

(12) Guidelines for the independent evaluation of all cases closed due to sanctions or time limits;

(13) A micro-lending program and an individual development trust account demonstration project for program recipients;

(14) Criteria for relocation of program recipients which take into account factors, including, but not limited to, job availability, availability of support services, and proximity of relocation area to current residence;

(15) Criteria for prioritizing work activities of program recipients in the event that funds are projected to be insufficient to support full-time work activities of program recipients. The criteria may include, but not be limited to, priorities based on the following:

(A) At least one (1) adult in each two-parent family shall be assigned priority for full-time work activities;

(B) Among single-parent families, a family that has older pre-school children or school-age children shall be assigned priority for work activities;

(C) A recipient who has access to nonsubsidized child care may be assigned priority for work activities; and

(D) Priority may be assigned based on the amount of time remaining until the recipient reaches the applicable time limit for program participation or may be based on requirements of a personal responsibility agreement; and

(16) The development of a performance-based payment structure to be used for all program services which takes into account the degree of difficulty associated with placing a program recipient in a job, the quality of placement with regard to salary, benefits, and opportunities for advancement, and the recipient's retention of the placement. The payment structure should provide, if appropriate, bonus payments to providers that experience notable success in achieving long-term job retention with program recipients.

(c)(1)(A) The Department of Workforce Services shall prepare a comprehensive annual program report.

(B) The report shall be subject to review and recommendation by the board.

(2) The Department of Workforce Services shall submit the comprehensive annual program report to the Governor, the House Committee on Public Health, Welfare, and Labor, and the Senate Committee on Public Health, Welfare, and Labor.

(3) The comprehensive annual program report shall contain proposals for measuring and making progress toward the transitional employment assistance outcomes during the succeeding three-year period.



(4) The comprehensive annual program report to the Governor, the House Committee on Public Health, Welfare, and Labor, and the Senate Committee on Public Health, Welfare, and Labor shall include all information that the board deems necessary for determining progress in achieving the outcomes.

(5) Information shall be provided for the state, each employment opportunity district, and each county.

(6) The report shall also include all information requested by resolution of the House Committee on Public Health, Welfare, and Labor and the Senate Committee on Public Health, Welfare, and Labor.

(7) This report shall include a copy of all federal monthly, quarterly, and annual reports submitted by the Department of Human Services regarding the Temporary Assistance for Needy Families Program.

(d) The House Committee on Public Health, Welfare, and Labor and the Senate Committee on Public Health, Welfare, and Labor shall report annually to the General Assembly their findings and recommendations regarding the program.

**History.** Acts 1997, No. 1058, § 4; 1999, No. 1567, § 7; 2001, No. 1264, § 4; 2005, No. 1705, § 7; 2007, No. 514, §§ 3, 4; 2009, No. 415, § 1; 2011, No. 817, § 1.

**Amendments.** The 2009 amendment deleted (d) and redesignated the subsequent subsection accordingly; and in (d), deleted “the Senate Committee on Children and Youth, and the Subcommittee on Children and Youth of the House Commit-

tee on Aging, Children and Youth, Legislative and Military Affairs,” and made a related change.

The 2011 amendment substituted “comprehensive annual program report” for “annual transitional employment assistance implementation plan” in (c)(1)(A), for “quarterly progress reports” in (c)(2) and (c)(4), and for “annual updated plan” in (c)(3).

## 20-76-107. [Repealed.]

**A.C.R.C. Notes.** “Pursuant to Acts 2009, No. 952, § 20, the amendment of § 20-76-107(a)(3)(A) by Acts 2009, No. 952, § 12, is superseded by the repeal of § 20-76-107 by Acts 2009, No. 150, § 1.”

**Publisher’s Notes.** This section, con-

cerning the independent evaluator, was repealed by Acts 2009, No. 150, § 1. The section was derived from Acts 1997, No. 1058, § 4; 1999, No. 1567, § 8; 2001, No. 1264, § 5; 2003, No. 1306, § 4; 2007, No. 514, § 5.

## 20-76-108. [Repealed.]

**Publisher’s Notes.** This section, concerning local transitional employment assistance coalitions, was repealed by Acts

2005, No. 1705, § 8. This section was derived from Acts 1997, No. 1058, § 4; 1999, No. 1567, § 9.

## 20-76-109. Use of contracts.

The Department of Workforce Services, as appropriate, should provide work activities, training, and other services through contracts. In contracting for work activities, training, or services, the following apply:

(1)(A) A contract shall be performance-based.

(B) Whenever possible, payment shall be tied to performance outcomes that include factors such as, but not limited to, job entry, job entry at a target wage, and job retention, rather than tied to completion of training or education or any other phase of the program participation process;

(2)(A) A contract may include performance-based incentive payments that may vary according to the extent to which the recipient is more difficult to place.

(B)(i) Contract payments may be weighted proportionally to reflect the extent to which the recipient has limitations associated with the long-term receipt of welfare and difficulty in sustaining employment.

(ii) The factors may include the extent of the recipient's prior receipt of welfare, lack of employment experience, lack of education, lack of job skills, and other factors determined appropriate by the department;

(3) Each contract awarded under the Transitional Employment Assistance Program shall be awarded in accordance with state procurement and contract laws; and

(4)(A) The department may contract with commercial, charitable, or faith-based organizations.

(B) A contract must comply with federal requirements with respect to nondiscrimination and other requirements that safeguard the rights of participants.

(C) Services may be provided under contract, certificate, voucher, or other form of disbursement.

**History.** Acts 1997, No. 1058, § 4;  
2005, No. 1705, § 9.

## **20-76-110, 20-76-111. [Repealed.]**

**Publisher's Notes.** These sections concerning Arkansas Transitional Employment Assistance Transition Workgroup and transfers of powers, duties, and personnel, were repealed by Acts 2007, No.

514, § 6. The sections were derived from the following sources:

20-76-110. Acts 2005, No. 1705, §10.

20-76-111. Acts 2005, No. 1705, §10.

## **20-76-112. Human Services Workers in the Schools Program.**

(a) The Human Services Workers in the Schools Program is established as a collaborative effort among the Division of Children and Family Services of the Department of Human Services, the Temporary Assistance for Needy Families Oversight Board, the Department of Education, and local school districts. The Human Services Workers in the Schools Program is designed to help children and families by:

(1) Promoting safety of children and strengthening of families;

(2) Supporting the community's capacity to produce children who are healthy, children who are in supportive, nurturing, and healthy families, and children who succeed in school; and



(3) Promoting the division's family preservation philosophy and family-centered practice.

(b) Upon approval of the board, the division shall enter into contracts with local school districts to provide funding for the maximum number of human services workers.

(c) A human services worker shall have a bachelor's degree or a master's degree in social work or a related field and shall provide the following services according to skills and training:

- (1) Crisis intervention;
- (2) School conferences and in-service training;
- (3) Home visits;
- (4) Transportation for family and student group counseling;
- (5) Parent training and activities;
- (6) Supportive service referrals;
- (7) Individualized coping and conflict management skills; and
- (8) Assessment of family and student needs.

(d)(1) Funding for human services workers shall be targeted to schools with eighty percent (80%) or more of their children eligible for the Free and Reduced Lunch Program under the National School Lunch Act, 42 U.S.C. 1751 et seq.

(2) The Department of Education and the division shall develop criteria to prioritize eligibility for the Human Services Workers in the Schools Program.

(e) The Coordinated Health Services Section of the Department of Education shall evaluate the Human Services Workers in the Schools Program annually in coordination with the division, the board, and the local school districts that hold contracts.

(f) A parent or a student has the option to refuse any services recommended under the Human Services Workers in the Schools Program.

**History.** Acts 2005, No. 2295, § 1; 2007, No. 1050, § 1; 2009, No. 952, § 13; 2011, No. 1228, § 1.

**A.C.R.C. Notes.** Acts 2009, No. 952, § 13, omitted without striking through previously existing language in amending § 20-76-112(a). A.C.R.C. staff has determined that the omitted language was intended to be repealed and § 20-76-112(a) is set out above to reflect that intent.

**Amendments.** The 2009 amendment substituted "Human Services Workers in the Schools" for "Human Services in the School" in the section heading; substituted "Human Services Workers in the

Schools" for "Human Services in the School" in two places in (a), and for "Human Services Worker in the School" in (d)(2); substituted "National School Lunch Program" for "Free and Reduced Lunch program" in (d)(1); rewrote (e); substituted "the Human Services Workers in the Schools Program" for "this program" in (f) and made minor stylistic changes.

The 2011 amendment, in (d)(1), substituted "eighty percent (80%)" for "ninety percent (90%)" and "Free and Reduced Lunch Program" for "National School Lunch Program."

**20-76-113. Promoting outcomes for the Transitional Employment Assistance Program and the Arkansas Work Pays Program.**

(a) The administration of the Transitional Employment Assistance Program and the Arkansas Work Pays Program shall focus on promoting the following Transitional Employment Assistance Program outcomes for Transitional Employment Assistance Program recipients and poor families in Arkansas:

(1) Increase the percentage of families who receive appropriate services to move off of Transitional Employment Assistance Program cash assistance into employment and toward self-sufficiency;

(2) Increase the percentage of families who leave Transitional Employment Assistance Program cash assistance due to earnings from work;

(3) Increase earnings of families who leave Transitional Employment Assistance Program cash assistance;

(4) Increase the percentage of parents leaving Transitional Employment Assistance Program cash assistance who stay employed; and

(5) Increase the percentage of former Transitional Employment Assistance Program cash assistance recipients who move out of poverty, including the value of food stamps and the federal Earned Income Tax Credit and child support.

(b) The Department of Workforce Services shall develop and maintain the indicators for the Transitional Employment Assistance Program outcomes listed in subdivisions (a)(1)-(5) of this section, subject to review and approval by the Temporary Assistance for Needy Families Oversight Board.

(c)(1) The Department of Workforce Services shall develop proper targets for each Transitional Employment Assistance Program outcome by July 1 of each year, subject to review and approval by the board.

(2) The Department of Workforce Services shall review and report on progress in achieving the targets in the comprehensive annual program report.

(3)(A) On the forty-fifth day after the end of the federal fiscal year, the report shall be submitted to the Governor and to the Chair of the House Committee on Public Health, Welfare, and Labor and the Chair of the Senate Committee on Public Health, Welfare, and Labor.

(B) The report shall include comments from the Department of Human Services, the Department of Workforce Services, and other relevant state agencies about their activities and their progress toward the Transitional Employment Assistance Program outcome targets.

**History.** Acts 2007, No. 514, § 7; 2011, No. 817, § 2; 2013, No. 1132, § 42.

**Amendments.** The 2011 amendment substituted “in the comprehensive annual

program report” for “by December 10 and June 10 of each year” in (c)(2); and added “On the forty-fifth day after the end of the federal fiscal year” in (c)(3)(A).



The 2013 amendment deleted "Interim" twice following "Senate" and "House" in (c)(3)(A).

## SUBCHAPTER 2 — ADMINISTRATION GENERALLY

### SECTION.

20-76-201. Department of Human Services — Powers and duties.

### SECTION.

20-76-205. [Repealed.]

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**Effective Dates.** Acts 2007, No. 514, § 25: Mar. 27, 2007. Emergency clause provided: "It is found and determined by the General Assembly of the State of Arkansas that the state fiscal year begins July 1, 2007; that the state agencies responsible for the programs under this act require time to prepare for the program changes created in this act; that families in need of temporary assistance may not receive the needed assistance if this act does not become effective immediately; and that any delay in the effective date of this act could work irreparable harm on

families in need of temporary assistance. Therefore, an emergency is declared to exist and this act being necessary for the preservation of the public peace, health, and safety shall become effective on: (1) The date of its approval by the Governor; (2) If the bill is neither approved nor vetoed by the Governor, the expiration of the period of time during which the Governor may veto the bill; or (3) If the bill is vetoed by the Governor and the veto is overridden, the date the last house overrides the veto."

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### 20-76-201. Department of Human Services — Powers and duties.

The Department of Human Services shall:

(1) Administer assigned forms of public assistance, supervise agencies and institutions caring for dependent or aged adults or adults with mental or physical disabilities, and administer other welfare activities or services that may be vested in it;

(2) Administer or supervise all child welfare activities in accordance with the rules and regulations of the department, including:

(A) The licensing and supervision of private and public child care agencies and institutions;

(B) The care of dependent, neglected, and delinquent children and children with mental or physical disabilities in foster family homes or in institutions; and

(C) The care and supervision of children placed for adoption;

(3) Enter into reciprocal agreements with public welfare agencies in other states relative to the provisions of relief and assistance to transients and nonresidents and cooperate with other state departments and with the federal government in studying labor, health, and public assistance problems involved in transiency;

(4) Administer and make effective the rules and regulations governing personnel administration, including the preparation and adminis-

tration of classification and compensation plans and the method of selection for positions in the department:

(A) Develop performance standards and bonus awards for all positions in the program focused on achieving the outcomes; and

(B) Remove or transfer employees from the program to other responsibilities within the department if they do not meet performance standards;

(5) Carry on research and compile statistics relative to public welfare programs throughout the state, including all phases of dependency, defectiveness, delinquency, and related problems and develop plans in cooperation with other public and private agencies for the prevention as well as the treatment of conditions giving rise to public welfare problems;

(6) Assist other departments, agencies, and institutions of the state and federal governments, when so requested, by performing services in conformity with the purposes of this chapter;

(7) Cooperate with the federal government in matters of mutual concern pertaining to federally funded programs within the department's purview;

(8) Make reports in the form and containing the information as the federal government from time to time may require and comply with provisions as the federal government from time to time may find necessary to assure the correctness and veracity of the reports;

(9) Allocate funds for the purposes and in accordance with the provisions of this chapter and rules and regulations as may be prescribed by the department and subject to review and recommendation by the Temporary Assistance for Needy Families Oversight Board;

(10) Establish standards of eligibility for assistance developed by the department and subject to review and recommendation by the board;

(11) Receive, administer, disburse, dispose, and account for funds, commodities, equipment, supplies, and any kind of property given, granted, loaned, or advanced to the State of Arkansas for public assistance, public welfare, social security, or any other similar purposes;

(12) Make rules and regulations and take actions as are necessary or desirable to carry out the provisions of this chapter and that are not inconsistent therewith;

(13) Solicit participation of private organizations, nonprofit organizations, charitable organizations, and institutions of education in the delivery of services and in the enactment and revision of rules and regulations;

(14) Employ attorneys to represent the interests of the department; and

(15) Develop and implement automated statewide benefit delivery and information systems to achieve the purposes of this chapter.

**History.** Acts 1939, No. 280, § 7; A.S.A. 1997, No. 1058, § 5; 1999, No. 1567, § 10; 1947, § 83-109; Acts 1995, No. 710, § 6; 2001, No. 1264, § 6; 2007, No. 514, § 8.



**A.C.R.C. Notes.** Pursuant to § 1-2-124, the phrase “dependent or mentally or physically disabled or aged adults” in

§ 20-76-201(1) has been changed to “dependent or aged adults or adults with mental or physical disabilities”.

RESEARCH REFERENCES

**Ark. L. Rev.** An Accident Waiting to Happen: Arkansas Department of Health and Human Services v. Ahlborn Exposes

Inequities in Medical Benefits Legislation, 60 Ark. L. Rev. 533.

20-76-205. [Repealed.]

**Publisher’s Notes.** This section, concerning use of unspent federal assistance, was repealed by Acts 2007, No. 514, § 9.

The section was derived from Acts 2001, No. 1264, § 11.

SUBCHAPTER 3 — SOCIAL SECURITY DISABILITY DETERMINATION

**A.C.R.C. Notes.** Acts 2013, No. 926, § 4, provided: “EXTRA HELP RESTRICTION. No extra help employee of Disability Determination for Social Security Administration shall be employed for a

period of time to exceed eighteen hundred (1800) hours in any single fiscal year.

“The provisions of this section shall be in effect only from July 1, 2013 through June 30, 2014.”

SUBCHAPTER 4 — GRANTS OF ASSISTANCE

SECTION.

- 20-76-401. Eligibility generally — Transitional Employment Assistance Program.
- 20-76-402. Work activities.
- 20-76-404. Duration of assistance — Extended support services.
- 20-76-406. [Repealed.]
- 20-76-410. Administrative sanctions — Transitional employment assistance.
- 20-76-436. Recovery of benefits from recipients’ estates.

SECTION.

- 20-76-438. Purpose.
- 20-76-439. Self-sufficiency — Assessments, personal responsibility agreements, and supportive services.
- 20-76-441, 20-76-442. [Repealed.]
- 20-76-443. Education and training.
- 20-76-444. Arkansas Work Pays Program — Created — Duties.
- 20-76-445. Career Pathways Initiative.
- 20-76-446. Community Investment Initiative.

**Effective Dates.** Acts 2003, No. 1306, § 7: July 1, 2003. Emergency clause provided: “It is found and determined by the General Assembly of the State of Arkansas that it is crucial to the life and health of many needy citizens of the State of Arkansas that the outcomes of the transitional employment program are more clearly defined and monitored in order that these public assistance programs can be better focused on meeting the real

needs of needy Arkansans, that the United States Congress is in the process of reauthorizing the federal laws which guide and fund these programs, and that it is necessary, in order to avoid any disruption in federal funding, that the program outcomes be clearly defined so as to provide better information to the federal government about the progress of these programs in Arkansas. Therefore, an emergency is declared to exist and this act

being necessary for the preservation of the public peace, health, and safety shall become effective on July 1, 2003.”

Acts 2003, No. 1473, § 74: July 1, 2003. Emergency clause provided: “It is found and determined by the General Assembly of the State of Arkansas that this act includes technical corrects to Act 923 of 2003 which establishes the classification and compensation levels of state employees covered by the provisions of the Uniform Classification and Compensation Act; that Act 923 of 2003 will become effective on July 1, 2003; and that to avoid confusion this act must also [sic] effective on July 1, 2003. Therefore, an emergency is declared to exist and this act being necessary for the preservation of the public peace, health, and safety shall become effective on July 1, 2003.”

Acts 2005, No. 1705, § 20: Effective date clause provided:

“(a) Section 10 of this act shall become effective immediately upon enactment.

“(b) Sections 3, 6, 7, 9, 11, 12 and 14 through 18 shall become effective upon certification from the Directors of the Employment Security Department and the Department of Human Services with consent from the Governor and the Chair of the Senate Committee on Public Health, Welfare and Labor and the Chair of the House Committee on Public Health, Welfare and Labor.

“(c)(1) Section 19 shall become effective on January 1, 2006.

“(2) Within Section 19 of this act:

“(A) The effective date for the Arkansas Work Pays Program, Arkansas Code § 20-76-444, may be delayed up to July 1, 2006 if the Transitional Employment Board certifies to the Governor that the transfer of Transitional Employment Assistance Program will not take place until January 1, 2006 or later and that it is in the public interest that the effective date of Work Pays be delayed.

“(B) Arkansas Code § 20-76-445 shall become effective July 1, 2005.

“(C) Arkansas Code § 20-76-446 shall become effective on January 1, 2006.”

Acts 2005, No. 1705, § 21: July 1, 2005. Emergency clause provided: “It is found and determined by the General Assembly of the State of Arkansas that due to increasing requirements in the Transitional Employment Assistance Program amendments made in sections 4, 5, 8, 12, and 13 of this act are necessary for continued effectiveness of the program and provision of services to families. Therefore, an emergency is declared to exist and this act being necessary for the preservation of the public peace, health, and safety, section 10 will be in full force and effect immediately and sections 4, 5, 8, and 13 shall be in full force and effect on and after July 1, 2005.”

Acts 2007, No. 514, § 25: Mar. 27, 2007. Emergency clause provided: “It is found and determined by the General Assembly of the State of Arkansas that the state fiscal year begins July 1, 2007; that the state agencies responsible for the programs under this act require time to prepare for the program changes created in this act; that families in need of temporary assistance may not receive the needed assistance if this act does not become effective immediately; and that any delay in the effective date of this act could work irreparable harm on families in need of temporary assistance. Therefore, an emergency is declared to exist and this act being necessary for the preservation of the public peace, health, and safety shall become effective on: (1) The date of its approval by the Governor; (2) If the bill is neither approved nor vetoed by the Governor, the expiration of the period of time during which the Governor may veto the bill; or (3) If the bill is vetoed by the Governor and the veto is overridden, the date the last house overrides the veto.”

## **20-76-401. Eligibility generally — Transitional Employment Assistance Program.**

(a)(1) The Transitional Employment Assistance Program is created.

(2)(A) The program shall be administered by the Department of Human Services and the Department of Workforce Services.



(B) Subject to the order of the Governor, the Department of Workforce Services may take full authority for administering the Transitional Employment Assistance Program.

(C) The Department of Workforce Services may contract with the Department of Human Services for administrative services.

(3) The Department of Workforce Services may operate a separate Transitional Employment Assistance Program Two-Parent Program funded by state funds not claimed for the federal Temporary Assistance for Needy Families program maintenance of effort requirement if the Director of the Department of Workforce Services deems such action necessary to avoid the risk of not meeting the two-parent work participation rate.

(b) Eligibility for transitional employment assistance is limited to applicants for or recipients of assistance who:

(1) Are income and resource eligible; and

(2) Sign and comply with a personal responsibility agreement.

(c) The department shall promulgate regulations to determine resource eligibility and benefit levels for participating families. The regulations shall be subject to review and recommendation by the Temporary Assistance for Needy Families Oversight Board and shall include, but not be limited to, the following categories of income and resource disregards:

(1) To reward work, earned income from sources other than transitional employment assistance;

(2) A certain percentage of a family's gross monthly income;

(3) The family's homestead;

(4) An operable motor vehicle per family;

(5) Household and personal goods;

(6) Income-producing property;

(7) Moneys deposited in an approved individual development account or approved escrow account for business or career development;

(8) Any other property or resource specified in the transitional employment assistance implementation plan which is determined to be cost efficient to exclude or which must be excluded due to federal or state law; and

(9) Any investment earmarked for retirement or education, such as a retirement plan authorized by section 401(k) or section 529 of the Internal Revenue Code of 1986, as it existed on January 1, 2007.

(d) Any person who makes an application for assistance shall have the burden of proving eligibility for the assistance.

**History.** Acts 1939, No. 280, § 18; 1951, No. 229, § 1; 1953, No. 177, § 1; 1959, No. 301, § 1; A.S.A. 1947, §§ 83-123 — 83-123.2; Acts 1997, No. 1058, § 8; 1999, No. 1567, § 11; 2003, No. 1473, § 43; 2005, No. 1705, § 11; 2007, No. 514, § 10.

**U.S. Code.** Section 401(k) and section 529 of the Internal Revenue Code of 1986, as mentioned in this section, are codified at 26 U.S.C. § 401(k) and 26 U.S.C. § 529.

**RESEARCH REFERENCES**

**ALR.** Validity, construction, and application of state statutes limiting or barring public health care to indigent aliens. 113 A.L.R.5th 95.

**20-76-402. Work activities.**

(a) The Department of Workforce Services shall develop and describe categories of approved work activities for transitional employment assistance recipients in accordance with this section. The rules shall be subject to review and recommendation by the Temporary Assistance for Needy Families Oversight Board. Approved work activities may include unsubsidized employment, subsidized private sector employment, subsidized public sector employment, education or training, vocational educational training, skills training, job search and job readiness assistance, on-the-job training, micro enterprise, community service, and work experience. For purposes of this section:

(1) "Unsubsidized employment" is full-time employment or part-time employment that is not directly supplemented by federal or state funds;

(2)(A) "Subsidized private sector employment" is employment in a private for-profit enterprise or a private not-for-profit enterprise which is directly supplemented by federal or state funds. A program recipient in subsidized private sector employment shall be eligible for the same benefits as a nonsubsidized employee who performs similar work. Prior to receiving any subsidy or incentive, an employer shall enter into a written contract with the department which may include, but not be limited to, provisions addressing any of the following:

(i) Payment schedules for any subsidy or incentive such as deferred payments based on retention of the recipient in employment;

(ii) Durational requirements for the employer to retain the recipient in employment;

(iii) Training to be provided to the recipient by the employer;

(iv) Contributions, if any, made to the recipient's individual development account; and

(v) Weighting of incentive payments proportionally to the extent to which the recipient has limitations associated with the long-term receipt of welfare and difficulty in sustaining employment. In establishing incentive payments, the Department of Workforce Services shall consider the extent of the recipient's prior receipt of welfare, lack of employment experience, lack of education, lack of job skills, and other appropriate factors.

(B) The Department of Workforce Services may require an employer to repay some or all of a subsidy or incentive previously paid to an employer under the program unless the recipient is terminated for cause;

(3)(A) "Subsidized public sector employment" is employment by an agency of the federal, state, or local government which is directly supplemented by federal or state funds. A program recipient in subsidized public sector employment shall be eligible for the same



benefits as a nonsubsidized employee who performs similar work. Prior to receiving any subsidy or incentive, an employer shall enter into a written contract with the Department of Workforce Services that may include, but not be limited to, provisions addressing any of the following:

- (i) Payment schedules for any subsidy or incentive such as deferred payments based on retention of the recipient in employment;
- (ii) Durational requirements for the employer to retain the recipient in employment;
- (iii) Training to be provided to the recipient by the employer;
- (iv) Contributions, if any, made to the recipient's individual development account; and
- (v) Weighting of incentive payments proportionally to the extent to which the recipient has limitations associated with the long-term receipt of welfare and difficulty in sustaining employment. In establishing incentive payments, the Department of Workforce Services shall consider the extent of the recipient's prior receipt of welfare, lack of employment experience, lack of education, lack of job skills, and other appropriate factors.

(B) The Department of Workforce Services may require an employer to repay some or all of a subsidy and incentive previously paid to an employer under the program unless the recipient is terminated for cause;

(4) "Work experience" is job-training experience at a supervised public or private not-for-profit agency or organization or with a private for-profit employer which is linked to education or training and substantially enhances a recipient's employability. Work experience may include work study, training-related practicums, and internships;

(5) "Job search assistance" may include supervised or unsupervised job-seeking activities. Job readiness assistance provides support for job-seeking activities, which may include:

(A) Orientation in the world of work and basic job-seeking and job-retention skills;

(B) Instruction in completing an application for employment and writing a resume;

(C) Instruction in conducting oneself during a job interview, including appropriate dress;

(D) Providing a recipient with access to an employment resource center that contains job listings, telephones, facsimile machines, typewriters, and word processors; and

(E) Preparation to seek or obtain employment, including life skills and literacy training, and substance abuse treatment, mental health treatment, or rehabilitation activities for those who are otherwise employable;

(6) "Education" includes elementary and secondary education, education to obtain the equivalent of a high school diploma, and education to learn English as a second language. In consultation with adult education or rehabilitative services, a person with a high school

diploma or the equivalent who tests at less than a working functioning level shall be eligible to participate in basic remedial or adult education. If an individual does not have a high school diploma or equivalency, "education" also includes basic remedial education and adult education;

(7) "Vocational educational training" is postsecondary education, including, at least, programs at two-year or four-year colleges, universities, technical institutes, and vocational schools or training in a field directly related to a specific occupation;

(8) Job skills training directly related to employment provides job skills training in a specific occupation. Job skills training may include customized training designed to meet the needs of a specific employer or a specific industry;

(9) "On-the-job training" means training and work experience at a public or private not-for-profit agency or organization or with a private for-profit employer which provides an opportunity to obtain training and job supervision and provides employment upon satisfactory completion of training;

(10) School attendance at a high school or attendance at a program designed to prepare the recipient to receive a high school equivalency diploma is a required program activity for each recipient eighteen (18) years of age or younger who:

(A) Has not completed high school or obtained a high school equivalency diploma;

(B) Is a dependent child or a head of household; and

(C) For whom it has not been determined that another program activity is more appropriate;

(11) Participation in medical, educational, counseling, and other services that are part of the recipient's personal responsibility agreement is a required activity for each teen parent who participates in the Transitional Employment Assistance Program; and

(12) "Community service" is time spent engaged in an approved activity at a government entity or community-based, charitable organization.

(b) All occupational training must meet at least one (1) of the following requirements:

(1) Be on the statewide or appropriate area list of occupations in the "Guide to Educational Training Program for Demand Occupations" published by the Department of Workforce Services;

(2) Be on that list for another area within the state to which the program recipient has signed a commitment to relocate;

(3) Be for a specific position for which an employer has submitted a letter demonstrating intent to hire persons upon successful completion of training; and

(4) Be in an occupation in local demand but not shown on the state or area demand list if the local demand is documented or will be documented by the area workforce investment board through a state-prescribed methodology.

(c) Each state agency and each entity that contracts to provide services for a state agency shall establish recruitment and hiring goals



which shall target ten percent (10%) of all jobs requiring a high school diploma or less to be filled with transitional employment assistance or food stamp recipients.

(d)(1) The Department of Workforce Services shall require participation in approved work activities to the maximum extent possible, subject to federal and state funding. If funds are projected to be insufficient to support full-time work activities by all program recipients who are required to participate in work activities, the Department of Workforce Services shall screen recipients and assign priority in accordance with the implementation plan.

(2) In accordance with the implementation plan, the Department of Workforce Services may limit a recipient's weekly work requirement to the minimum required to meet federal work activity requirements and may develop screening and prioritization procedures within employment opportunity districts or within counties based on the allocation of resources, the availability of community resources, or the work activity needs of the employment opportunity district or county.

(e)(1) Subject to subdivision (e)(2) of this section, an adult in a family receiving assistance under the program may fill a vacant employment position in order to engage in a work activity described in subsection (a) of this section.

(2) No adult in a work activity described in subsection (a) of this section which is funded, in whole or in part, by funds provided by the federal government shall be employed or assigned:

(A) When any other individual is on layoff from the same or any substantially equivalent job; or

(B) If the employer has terminated the employment of any regular employee or otherwise caused an involuntary reduction in its workforce in order to fill the vacancy so created with an adult described in subdivision (e)(1) of this section.

(3) The Department of Workforce Services shall establish and maintain a grievance procedure for resolving complaints of alleged violations of subdivision (e)(2) of this section.

(4) Nothing in this subsection (e) shall preempt or supersede any provision of state or local law that provides greater protection for employees from displacement.

(f) The Department of Workforce Services, subject to review and recommendation by the board, shall establish criteria to exempt or temporarily defer the following persons from any work activity requirement:

(1) An individual required to care for a recipient child until the child reaches twelve (12) months of age, if the caregiver is an active participant in a home-based or part-time center-based quality-approved early learning program, where available, that requires parental involvement and is approved by the Department of Education under the Arkansas Better Chance Program Act, § 6-45-101 et seq.;

(2) An individual required to care for a recipient child until the child reaches the maximum age specified by regulation, not to exceed twelve (12) months of age;

(3) A disabled parent or caregiver, based upon criteria set forth in regulations;

(4) A woman in the third trimester of pregnancy;

(5) A parent or caregiver who is caring for a disabled child relative or disabled adult relative, based upon criteria set forth in regulations;

(6) A minor parent less than eighteen (18) years of age who resides in the home of a parent or in an approved adult-supervised setting and who participates in full-time education or training;

(7) A teen parent head of household under the age of twenty (20) who maintains satisfactory attendance as a full-time student at a secondary school;

(8) An individual for whom support services necessary to engage in a work activity are not available;

(9) An individual who, as determined by a Department of Workforce Services case manager, is unable to participate in work activities due directly to the effects of domestic violence. All case manager determinations made under this subdivision (f)(9) shall be reviewed by a supervisor within five (5) days of such determination;

(10) An individual unable to participate in a work activity due to extraordinary circumstances;

(11) A parent or caregiver over sixty (60) years of age; and

(12) Child-only cases.

**History.** Acts 1979, No. 667, §§ 1-3; A.S.A. 1947, §§ 83-123.3 — 83-123.5; Acts 1997, No. 1058, § 9; 1999, No. 1567, § 12; 2003, No. 1306, § 5; 2005, No. 1705, § 12; 2007, No. 514, § 10.

**A.C.R.C. Notes.** Acts 2005, No. 1705, § 20(b), provided: "Sections 3, 6, 7, 9, 11, 12 and 14 through 18 shall become effective

upon certification from the Directors of the Employment Security Department and the Department of Human Services with consent from the Governor and the Chair of the Senate Committee on Public Health, Welfare and Labor and the Chair of the House Committee on Public Health, Welfare and Labor."

## RESEARCH REFERENCES

**U. Ark. Little Rock L. Rev.** Survey of Legislation, 2003 Arkansas General Assembly, Public Health and Welfare, Trans-

sitional Employment Assistance Program, 26 U. Ark. Little Rock L. Rev. 466.

### 20-76-404. Duration of assistance — Extended support services.

(a)(1) Beginning July 1, 1998, the Department of Workforce Services shall not provide financial assistance to a family that includes an adult recipient who has received financial assistance for more than twenty-four (24) months, except as provided in subsection (c) of this section.

(2) The number of months need not be consecutive and shall include the time a recipient receives financial assistance from another state.

(3) The Department of Workforce Services may by regulation establish other limitations on the receipt of financial assistance not inconsistent with state or federal law.

(b)(1) The Department of Workforce Services shall certify to the Governor, the House Committee on Public Health, Welfare, and Labor,



and the Senate Committee on Public Health, Welfare, and Labor when the support services necessary for program recipients to obtain employment or participate in allowable work activities are available.

(2) The Department of Workforce Services may certify subsets of program recipients, including, but not limited to, recipients in a certain geographical area or employment opportunity district or program recipients with a high school diploma or general educational development certificate.

(3) Prior to implementing the twenty-four-month cumulative limit on financial assistance, the Department of Workforce Services shall notify program recipients by direct mail or contact and by other means reasonably calculated to reach to current and potential program recipients, including, but not limited to, the posting of notices in county offices.

(c) The Department of Workforce Services shall exempt or temporarily defer within thirty (30) calendar days the following persons from the twenty-four-month cumulative limit on financial assistance:

(1) An individual, as determined by a Department of Workforce Services case manager, who cooperated and participated in activities, but was unable to obtain employment because of circumstances or barriers beyond his or her control;

(2) Child-only cases;

(3) An individual unable to obtain employment because of the lack of support services necessary to overcome barriers to employment;

(4) A parent or caregiver over sixty (60) years of age;

(5) A parent or caregiver who is caring for a disabled child relative or disabled adult relative, based upon criteria set forth in the Department of Workforce Services' regulations;

(6) A disabled parent or caregiver, based upon criteria set forth in the Department of Workforce Services' regulations;

(7) A parent less than eighteen (18) years old who resides in the home of a parent or in an approved adult-supervised setting and who participates in full-time education or training;

(8) An individual, who as determined by a Department of Workforce Services case manager, is unable to obtain employment due directly to the effects of domestic violence. All case manager determinations made under this subdivision (c)(8) shall be reviewed by a supervisor within five (5) days of the determination;

(9) Other individuals as determined by the Department of Workforce Services, including, but not limited to, a child when necessary to protect the child from the risk of neglect, as defined by § 12-18-103(6); and

(10) Individuals participating in education and training activities who have reached the end of their twenty-four-month cumulative limit on financial assistance, have complied with all transitional employment assistance regulations, are making satisfactory academic progress as determined by the academic institution or training program in which the individual is currently enrolled, and are expected to complete the requirements for the education or training program within a reasonable

period of time as defined in regulations issued by the Department of Workforce Services.

(d)(1) No months shall be counted toward a person's twenty-four-month cumulative limit on financial assistance while he or she is receiving a deferral or exemption.

(2) There shall be no limit on the length or the number of deferrals or exemptions granted each person as long as the person meets any of the criteria outlined in § 20-76-404(c)(1)-(10).

(3) The Department of Workforce Services shall periodically review each case to determine whether the person still meets any of the criteria outlined in § 20-76-404(c)(1)-(10).

(4)(A) The Department of Workforce Services shall carry out an enhanced review of all cases six (6) months before the expiration of the time limit.

(B) The review shall assess the barriers that remain to the adult or adults in the case obtaining employment, what enhanced services can be provided to enable him or her to obtain employment, and whether the case should be given a six-month extension or be exempted from the time limit.

(C) The Department of Workforce Services shall make every reasonable effort to deliver the available services identified in subdivision (d)(4)(B) of this section.

(D) The Department of Workforce Services shall grant an extension at the time for review if the client meets one (1) of the grounds for extension.

(E) The Department of Workforce Services shall carry out a further review at the end of the extension period.

(e)(1) A recipient who was eligible for Medicaid and loses his or her financial assistance due to earnings and whose income remains below one hundred eighty-five percent (185%) of the federal poverty level shall remain eligible for transitional Medicaid without reapplication during the immediately succeeding twelve-month period if private medical insurance is unavailable from the employer.

(2) A recipient who loses his or her financial assistance due to earnings and who is employed shall be eligible for:

(A) Child care assistance at no cost and without reapplication for a cumulative period of twelve (12) months; and

(B) Twenty-four (24) additional months of child care assistance provided on a sliding fee scale or other cost-sharing arrangement as determined by the Department of Workforce Services.

(3) The Department of Workforce Services may reduce the period of transitional child care to a total of twenty-four (24) months for recipients who lose assistance at a specified date after the Department of Workforce Services' decision to limit the assistance if the Department of Workforce Services certifies to the Governor and the Chief Fiscal Officer of the State that the reduction is necessary to avoid overspending the biennial budget for child care.

(4) The transitional child care assistance available to former recipients shall not exceed the cumulative number of months provided under



subdivisions (e)(2) and (3) of this section, regardless of whether the former recipient reenters the Transitional Employment Assistance Program.

(f)(1) The Department of Workforce Services shall deny Medicaid, child care, and transportation assistance during the twelve-month period for any month in which the recipient's family does not include a dependent child.

(2) The Department of Workforce Services shall notify the recipient of transitional Medicaid, child care, and transportation assistance when the recipient is notified of the termination of cash assistance. The notice shall include a description of the circumstances in which the transitional Medicaid and child care assistance may be terminated.

(g)(1) In order to assist current and former program recipients in continuing training and upgrading skills, transitional education or training may be provided to a recipient for up to one (1) year after the recipient is no longer eligible to participate in the program due to employment earnings.

(2) Education or training resources available in the community at no additional cost to the Department of Workforce Services shall be used whenever possible.

(3) Transitional education or training shall be employment-related and may include education or training to improve a recipient's job skills in the recipient's existing area of employment or may include education or training to prepare a recipient for employment in another occupation.

(4) The Department of Workforce Services may enter into an agreement with an employer to share the costs relating to upgrading the skills of recipients hired by the employer.

(h) Other extended support services may be available to recipients no longer eligible for financial assistance under transitional employment assistance.

(i)(1) By August 1, 2001, the Department of Workforce Services shall develop a plan, subject to review and recommendation by the Temporary Assistance for Needy Families Oversight Board, to monitor and protect the safety and well-being of the children within a family whose temporary assistance is terminated for any reason other than the family's successful transition to economic self-sufficiency.

(2)(A) Actions required by the plan shall include at least one (1) home visit with the parents and children.

(B) Every reasonable effort shall be made to make contact with all families, including visits during evenings and on weekends.

(C) The first home visit shall occur within six (6) months after the termination of cash assistance.

(D) The purposes of the home visits shall include checking on the well-being of children in those families and determining whether the families need available services.

(3) The Department of Workforce Services may contract with other state agencies, private companies, local government agencies, or community organizations for the conducting of these visits.

(4) The board shall submit a report to the Governor and the chairs of the House Committee on Public Health, Welfare, and Labor and the Senate Committee on Public Health, Welfare, and Labor that report on the outcomes of the home visits and provide separate information for families who left transitional assistance due to noncompliance and time limits.

(j) As part of the home visits, families shall be informed about the availability of Medicaid and ARKids First, food stamps, child care, housing assistance, any other supportive services offered by the Department of Workforce Services or the Department of Health designed to help meet the basic needs and well-being of children, federal and state earned income tax credits, individual development accounts, employment counseling services, and education and training opportunities designed to increase the future earnings and employment prospects of clients.

**History.** Acts 1953, No. 231, § 7; A.S.A. 1947, § 83-129.1; Acts 1997, No. 1058, § 11; 1999, No. 1567, § 13; 2001, No. 1264, §§ 7, 8; 2007, No. 514, §§ 11, 12, 13; 2009, No. 758, § 27.

**A.C.R.C. Notes.** The contingency in Acts 2009, No. 758, § 29, was met by Acts 2009, No. 749.

**Amendments.** The 2009 amendment substituted “§ 12-18-103(6)” for “§ 12-12-503(6)” in (c)(9), and made minor stylistic changes.

**Effective Dates.** Acts 2009, No. 758, § 29, provided: “Contingent Effectiveness. This act shall not become effective unless an act of the Eighty-Seventh General Assembly repealing the Arkansas Child Maltreatment Act, § 12-12-501 et seq., and enacting a new Child Maltreatment Act, § 12-18-101 et seq., becomes effective.”

## 20-76-406. [Repealed.]

**Publisher’s Notes.** This section, concerning alternative benefits, was repealed by Acts 2007, No. 514, § 14. The section was derived from Acts 1939, No. 280,

§ 26; 1949, No. 192, §§ 1, 2; 1965 (2nd Ex. Sess.), No. 14, § 5; A.S.A. 1947, §§ 83-132 — 83-132.2; Acts 1997, No. 1058, § 13; 2005, No. 1705, § 13.

## 20-76-410. Administrative sanctions — Transitional employment assistance.

(a) A reduction in financial assistance or case closure shall be imposed in the following situations:

- (1) The individual fails without good cause to cooperate with the Office of Child Support Enforcement;
- (2) The individual refuses to accept employment without good cause;
- (3) The individual quits employment without good cause;
- (4) The individual fails without good cause to comply with the provisions of the employment plan;
- (5) The individual fails without good cause to comply with the provisions of the personal responsibility agreement; or
- (6) The individual flees prosecution or custody or confinement following conviction or is in violation of the terms or conditions of parole or probation.



(b) The Department of Workforce Services may define by rule additional situations that require sanction, establish additional sanctions, and provide for administrative disqualification.

(c)(1) If a parent fails to comply with the Transitional Employment Assistance Program requirements, financial assistance for the child or children may be continued under subdivisions (a)(1)-(5) of this section, and the department shall suspend the family's assistance for one (1) month.

(2)(A) During the thirty (30) days after suspension of benefits, the department shall make strong efforts to arrange a face-to-face meeting with the parent, including a home visit to the family if necessary.

(B) In the face-to-face meeting, the department shall explain:

(i) The reason that the family has been found to be noncompliant;

(ii) The penalty that will be imposed; and

(iii) The opportunity to correct that noncompliance and avoid the penalty.

(C) The department shall also seek to determine the well-being of the child or children and whether additional services or actions are required to protect the well-being of the child or children.

(D) If the parent comes into compliance within fifteen (15) business days after the face-to-face meeting and maintains compliance for two (2) weeks, the suspended benefits shall be paid to the family.

(3) If the parent fails to come into compliance during the period of suspended benefits, the family's financial assistance may be reduced by up to twenty-five percent (25%) for the next three (3) months if noncompliance continues.

(4) If the parent's noncompliance continues after the fourth month, the department shall suspend the family's financial assistance for two (2) months.

(5)(A) During the thirty (30) days after suspension of benefits, the department shall make strong efforts to arrange a face-to-face meeting with the parent, including a home visit to the family if necessary.

(B) In the face-to-face meeting, the department shall explain:

(i) The reason that the family has been found to be noncompliant;

(ii) The penalty that will be imposed; and

(iii) The opportunity to correct that noncompliance and avoid the penalty.

(C) The department shall also seek to determine the well-being of the child or children and whether additional services or actions are required to protect the well-being of the child or children.

(D) If the parent comes into compliance within fifteen (15) business days and maintains compliance for two (2) weeks, the suspended benefits shall be paid to the parent.

(E) If the parent fails to come into compliance during the second period of suspended benefits, the family's financial assistance may be reduced by up to fifty percent (50%) for the next three (3) months, if noncompliance continues.

(F) Months during which cash assistance benefits are suspended shall not count toward the family's twenty-four-month limit on receiving Transitional Employment Assistance Program assistance.

(G) The Transitional Employment Assistance Program cash assistance case shall be closed if noncompliance continues after the end of the period under this subdivision (c)(5).

(6) The department shall arrange a home visit with the family during the last month of the sanction to determine the well-being of the child or children and to determine whether additional services are required to protect the well-being of the child or children.

(7) Medicaid and food stamp benefits shall be continued without need for reapplication if the family is being sanctioned and for as long as the family remains eligible under the requirements of those programs.

(8) Department staff may contract with other state agencies, local coalitions, or appropriate community organizations to carry out the strong efforts to communicate with families facing sanction and to conduct the face-to-face meetings and home visits specified in this section.

(d) Beginning after July 27, 2011, the department shall include in the comprehensive annual program report information on the families sanctioned and the outcomes of the home visits to the Governor and the House Committee on Public Health, Welfare, and Labor and the Senate Committee on Public Health, Welfare, and Labor.

(e) When appropriate, protective payees may be designated by the department and may include:

(1) A relative or other individual who is interested in or concerned with the welfare of the child or children and agrees in writing to utilize the assistance in the best interests of the child or children;

(2) A member of the community affiliated with a religious, community, neighborhood, or charitable organization who agrees in writing to utilize the assistance in the best interests of the child or children; or

(3) A volunteer or member of an organization who agrees in writing to utilize the assistance in the best interests of the child or children.

(f)(1) If it is in the best interest of the child or children, as determined by the department, for the staff member of a private agency, a public agency, the department, or any other appropriate organization to serve as a protective payee, the designation may be made.

(2) However, a protective payee shall not be any individual involved in determining eligibility for assistance for the family, staff handling any fiscal pressures related to the issuance of assistance, or landlords, grocers, or vendors of goods, services, or items dealing directly with the recipient.

**History.** Acts 1939, No. 280, § 21; §§ 83-127 — 83-127.2; Acts 1997, No. 1953, No. 177, § 3; 1957, No. 314, § 1; 1058, § 17; 1999, No. 1567, § 15; 2001, No. 1264, § 9; 2005, No. 1705, § 14; 2007, No. 514, § 15; 2011, No. 817, § 3; 2013, § 3; 1983, No. 780, §§ 1, 2; A.S.A. 1947, No. 1132, §§ 43, 44.



**A.C.R.C. Notes.** Acts 2005, No. 1705, § 20(b), provided: “Sections 3, 6, 7, 9, 11, 12 and 14 through 18 shall become effective upon certification from the Directors of the Employment Security Department and the Department of Human Services with consent from the Governor and the Chair of the Senate Committee on Public Health, Welfare and Labor and the Chair of the House Committee on Public Health, Welfare and Labor.”

**Amendments.** The 2011 amendment, in (d), substituted “after the effective date of this act” for “January 1, 2008” and “include in the comprehensive annual program report information” for “submit bi-annual reports.”

The 2013 amendment deleted “Interim” twice following “Senate” and “House” in (d); and redesignated former (e)(4)(A) and (e)(4)(B) as present (f)(1) and (f)(2).

## **20-76-436. Recovery of benefits from recipients’ estates.**

(a)(1) Federal or state benefits in cash or in kind, including, but not limited to, Medicaid, Aid to Families with Dependent Children, Transitional Employment Assistance, Temporary Assistance for Needy Families, and food stamps distributed or paid by the Department of Human Services as well as charges levied by the department for services rendered shall upon the death of the recipient constitute a debt to be paid.

(2)(A) The department may make a claim against the estate of a deceased recipient or the interest acquired from the deceased recipient by a grantee of a beneficiary deed under § 18-12-608 for the amount of any benefits distributed or paid or charges levied by the department.

(B) If a grantee of a beneficiary deed under § 18-12-608 makes a written request for a release or disclaimer of the department’s interest in the real property described in the beneficiary deed, the department within thirty (30) calendar days of the request shall either:

(i) Make a claim against the interest acquired from the deceased recipient by a grantee of the beneficiary deed; or

(ii) Provide the requested disclaimer and a release suitable for recording in the real estate records of the county where the real property is located.

(b)(1) The department shall not seek recovery against the estate of a deceased recipient or the interest acquired from the deceased recipient by a grantee of a beneficiary deed under § 18-12-608 for the amount of any benefits distributed or paid or charges levied if the recovery is not cost effective or if the recovery works an undue hardship on the heirs or devisees of the decedent’s estate or the grantee of a beneficiary deed under § 18-12-608.

(2) In determining the existence of an undue hardship, the department shall consider factors including, but not limited to, the following:

(A) The asset subject to recovery is the sole income-producing asset of the beneficiaries of the estate or the grantee of a beneficiary deed under § 18-12-608;

(B) Without receipt of the beneficiary deed or proceeds of the estate, a grantee or beneficiary would become eligible for federal or state benefits;

(C) Allowing a grantee of a beneficiary deed under § 18-12-608 to receive the interest under the beneficiary deed or a beneficiary to receive the inheritance from the estate would enable the grantee or beneficiary to discontinue eligibility for federal or state benefits;

(D) The asset subject to recovery is a home with a value of fifty percent (50%) or less of the average price of homes in the county where the homestead is located, as of the date of the deceased recipient's death; or

(E) There are other compelling circumstances.

(c) To the extent that there is any conflict between the preceding criteria and the standards that may be specified by the Secretary of the United States Department of Health and Human Services, the federal standards shall prevail.

(d) Applicants for federal or state benefits shall be notified in writing in prominent type on the application form that the department may make a claim against their estate or the interest acquired from the applicant by a grantee of a beneficiary deed under § 18-12-608.

**History.** Acts 1993, No. 415, § 1; 1997, No. 957, § 1; 1997, No. 1058, § 25; 2001, No. 1480, § 1; 2007, No. 243, § 2.

## **20-76-438. Purpose.**

(a)(1) The General Assembly finds that it is important that all families in this state be strong and economically self-sufficient and that it is in the public interest that:

(A) Eligible persons and families of lesser means be given time-limited cash assistance along with an opportunity to obtain and retain employment that is sufficient to sustain their families;

(B) As a part of this transition from welfare to work, it is in the public's interest that various supportive services and, in some cases, education and training be offered to these families to enable them to make this transition;

(C) Education and training are essential to long-term career development and self-sufficiency; and

(D) Employment improves the quality of life for parents and children by increasing family income and assets and by improving self-esteem.

(2) Therefore, it is in the public interest that our state provide time-limited cash assistance and supportive services to our most vulnerable citizens and their children.

(b)(1) The General Assembly also finds that:

(A) Currently there are inefficiencies and duplication of effort on the part of the Department of Workforce Services and the Department of Human Services in the administration of the Transitional Employment Assistance Program; and

(B) A different division of responsibility for administration of the Transitional Employment Assistance Program by the Department of Workforce Services and the Department of Human Services may



result in the more efficient and effective administration of the program.

(2) Therefore, it is in the public interest that the General Assembly authorize the Department of Workforce Services to:

(A) Receive the Temporary Assistance for Needy Families block grant from the United States Department of Health and Human Services for the administration of all Temporary Assistance for Needy Families-funded programs in Arkansas;

(B) Expend the Temporary Assistance for Needy Families block grant funds subject to the appropriations of the General Assembly;

(C) Provide all employment-related services for time-limited Transitional Employment Assistance Program clients;

(D) Contract with other state agencies or other providers to deliver services in Temporary Assistance for Needy Families-funded programs; and

(E) Prepare and submit any Temporary Assistance for Needy Families renewal plans that are required in § 402 of the Social Security Act, 42 U.S.C. § 651 et seq.

**History.** Acts 1999, No. 1567, § 1; Assistance Program" for "TEA program" 2005, No. 1705, § 15; 2007, No. 514, § 16; in (b)(2)(E). 2009, No. 952, § 14; 2013, No. 1132, § 45. The 2013 amendment deleted (b)(2)(E)

**Amendments.** The 2009 amendment and redesignated former (b)(2)(F) as present (b)(2)(E).

### **20-76-439. Self-sufficiency — Assessments, personal responsibility agreements, and supportive services.**

(a)(1) At the time of application for transitional employment assistance, the Department of Human Services and the applicant shall sign a personal responsibility agreement.

(2) An applicant shall not be required to engage in job search activities if the applicant does not have available child care and transportation services.

(b)(1) Within thirty (30) calendar days after an application for transitional employment assistance has been approved, the department shall conduct an in-depth assessment of the functional educational level, skills, prior work experience, and employability of the participant.

(2) The department shall utilize testing instruments which shall yield education levels, skill levels, work readiness, and employability of the participant.

(3)(A) The assessment shall identify barriers to immediate employment as well as barriers that may prevent the participant from increasing his or her long-term earnings and from taking advantage of opportunities for employment advancement.

(B) The barriers to be assessed shall include, at least, domestic violence, substance abuse, learning disabilities, and unmet client needs for supportive services such as child care, transportation,

assistance with job-related expenses, housing, health care, job readiness preparation, and education and training.

(c) The department shall inform the participant of supportive services that may be available to alleviate barriers to employment and increase long-term earnings and opportunities for employment advancement.

(d) After the skills assessment has been completed and the participant has been informed about the availability of supportive services, the department shall work with the participant to develop an individual employment plan that:

(1) Sets forth an employment goal for the participant and a plan for moving the participant into employment;

(2) Is designed to the greatest extent possible to move the participant into employment, help the participant maintain employment, and increase the participant's long-term earnings and opportunities for employment advancement;

(3) Makes education and training a priority of allowable work activities, subject to federal work participation requirements and taking into account the caseload reduction credit, when the assessment warrants that education and training are the best means to achieving long-term economic self-sufficiency;

(4) Lists the supportive services that are generally available under the program and the methods by which a participant may access these services;

(5) Describes the services the department shall provide to enable participants to obtain and maintain employment and increase their potential long-term earnings and opportunities for employment advancement; and

(6) Designates the number of hours that he or she must participate in work activities to meet participation standards, unless the participant is deemed by the department to be exempt or temporarily deferred from work participation requirements.

(e)(1) The department shall review the progress of the participant in the program and meet with the participant as necessary to review and revise his or her employability plan.

(2) The department shall inform the participant of his or her time remaining on the lifetime limit on financial assistance and shall reassess the client's needs for supportive services.

(f) The department may develop and promulgate regulations requiring program applicants who have been determined to be job-ready to engage in job search activities while the application is being processed.

(g) The department shall not require an applicant to engage in job search activities if, in the judgment of the department, the applicant has one (1) or more barriers which if not addressed would prevent the applicant from finding employment.

(h)(1) Prior to requiring the applicant to engage in job search activities, the department shall ask the applicant whether child care or transportation assistance, or both, will be needed to complete job search activities.



(2) If needed child care and transportation are not available, the applicant shall not be required to engage in job search activities as a condition of application approval.

**History.** Acts 1999, No. 1567, § 18; 2007, No. 514, § 17.

### **20-76-441, 20-76-442. [Repealed.]**

**Publisher's Notes.** These sections, concerning transitional employment assistance postemployment information and referral program and customer service review program, were repealed by Acts 2007, No. 514, § 18. The sections were derived from the following sources:

20-76-441. Acts 1999, No. 1567, § 20; 2005, No. 1705, § 16.

20-76-442. Acts 1999, No. 1567, § 21; 2005, No. 1705, § 17.

### **20-76-443. Education and training.**

(a)(1) The Department of Human Services and the Department of Workforce Services shall permit Transitional Employment Assistance Program recipients to obtain the education and training they need to obtain jobs that pay wages allowing them to be economically self-sufficient.

(2) Program recipients who are assessed as having basic education deficiencies shall be allowed to combine educational activities leading to a high school diploma or general educational development certificate and employment and work experience. Participants may be required to engage in internships, work experience, or employment. Work requirements shall not exceed fifteen (15) hours per week unless the Department of Human Services certifies that allowing education to count toward program recipients' required work activities would affect the state's ability to meet federal work participation rates. To the extent possible, educational activities shall take place in a work context.

(3)(A) Qualified program recipients shall be allowed to enroll in vocational education courses designed to prepare them for jobs in high-growth, high-wage occupations.

(B) As long as the recipient's coursework, including study time, exceeds the minimum number of work activity hours required to count toward federal work participation rates, this activity alone shall satisfy the recipient's required work activity.

(C)(i) If a recipient's coursework, including study time, does not exceed the minimum number of work activity hours required to count toward federal work participation rates, the recipient may be required to engage in internships or work experience related to the course of study.

(ii) However, the combination of work activities and the recipient's coursework shall not exceed the minimum number of work activity hours required to count toward federal work participation rates.

(D)(i) The Department of Human Services may suspend the allowance to enroll only if the Temporary Assistance for Needy Families

Oversight Board certifies that allowing education to count toward a program recipient's required work activities would affect the state's ability to meet federal work participation rates.

(ii) Upon certification, the Department of Human Services may require all recipients to engage in work activities for the number of hours required to count toward the federal work participation rates.

(4)(A) Qualified program recipients shall be allowed to enroll in postsecondary courses leading to a two-year or four-year degree or a five-year teaching degree.

(B) As long as the recipient's coursework, including study time, exceeds the minimum number of work activity hours required to count toward federal work participation rates, this activity alone shall satisfy the recipient's required work activity.

(C)(i) If a recipient's coursework does not exceed the minimum number of work activity hours required to count toward federal work participation rates, the recipient may be required to engage in internships or work experience related to the course of study.

(ii) However, the combination of work activities and the recipient's coursework shall not exceed the minimum number of work activity hours required to count toward federal work participation rates.

(D)(i) The Department of Human Services may suspend the allowance to enroll only if the board certifies that allowing education to count toward a program recipient's required work activities would affect the state's ability to meet federal work participation rates.

(ii) Upon certification, the Department of Human Services may require all recipients to engage in work activities for the number of hours required to count toward the federal work participation rates.

(5) Participants under each of these options shall be provided the supportive services they need to attend classes and other educational activities, including, at least, child care and transportation.

(b) Program recipients shall be assigned to work activities that prepare them for long-term economic self-sufficiency, including basic, vocational, and postsecondary education when appropriate.

(c) Participation in combined work and education activities shall be deemed to meet program recipients' work activity requirements. The Department of Human Services may require additional or fewer hours of federally defined work activities if it certifies that the state may not meet federal work participation rates after taking into account the caseload reduction credit because recipients enrolled in educational courses are not required to engage in federally defined work activities for the minimum number of hours.

(d)(1) For a qualified program recipient enrolled in a two-year college, the education program created in this section shall pay for child care for the recipient's children for both day and evening classes.

(2) The Department of Workforce Services and the Arkansas Early Childhood Commission jointly shall promulgate rules to develop an evening child care program with extended hours under subdivision (d)(1) of this section.



**History.** Acts 1999, No. 1567, § 22; 2003, No. 1306, § 6; 2005, No. 1705, § 18; 2007, No. 514, §§ 19, 20; 2009, No. 1485, § 1; 2013, No. 1132, § 46.

**Amendments.** The 2009 amendment added (d).

The 2013 amendment substituted "Temporary Assistance for Needy Families Oversight Board" for "board" in (a)(3)(D)(i).

## RESEARCH REFERENCES

**U. Ark. Little Rock L. Rev.** Survey of Legislation, 2003 Arkansas General Assembly, Public Health and Welfare, Tran-

sitional Employment Assistance Program, 26 U. Ark. Little Rock L. Rev. 466.

### 20-76-444. Arkansas Work Pays Program — Created — Duties.

(a)(1) There is created the Arkansas Work Pays Program.

(2)(A) The Arkansas Work Pays Program shall be administered by the Department of Workforce Services.

(B) The administration of the Arkansas Work Pays Program shall focus on promoting the transitional employment assistance outcomes specified in § 20-76-113.

(3) Eligible applicants to the Arkansas Work Pays Program shall receive one (1) or more of the following:

(A) Cash assistance;

(B) Support services;

(C) Medical assistance; and

(D) Employment assistance.

(b)(1) Eligibility for assistance under the Arkansas Work Pays Program is limited to applicants or participants who:

(A) Have care and custody of a related minor child;

(B) Reside in the State of Arkansas at the time of application for assistance and during the period of assistance;

(C) Apply for program assistance within six (6) months of leaving the Transitional Employment Assistance Program after at least three (3) months of Transitional Employment Assistance Program assistance;

(D) Have not received more than twenty-four (24) months of Arkansas Work Pays Program benefits;

(E) Were engaged:

(i) In paid work activities for a minimum of twenty-four (24) hours per week and met the federal work participation requirement for the past month; or

(ii) In the case of continuing eligibility, in paid work activities for a minimum of twenty-four (24) hours per week and met the federal work participation requirement for one (1) of the past three (3) months and for at least three (3) of the past six (6) months;

(F) Are:

(i) Citizens of the United States;

(ii) Qualified aliens lawfully present in the United States before August 22, 1996;

(iii) Qualified aliens who physically entered the United States on or after August 22, 1996, and have been in qualified immigrant status for at least five (5) years; or

(iv) Aliens to whom benefits under Temporary Assistance for Needy Families must be provided under federal law;

(G) Have income below one hundred fifty percent (150%) of the federal poverty level; and

(H) Sign and comply with a personal responsibility agreement.

(2) Families who leave the Arkansas Work Pays Program due to insufficient work hours may reenter the Arkansas Work Pays Program once they establish that they were paid work activities for a minimum of twenty-four (24) hours per week and met the federal work participation requirement for the past month.

(c)(1) Families participating in the Arkansas Work Pays Program with earnings less than the federal poverty level shall receive monthly cash assistance equal to the maximum monthly Transitional Employment Assistance Program benefit for a family of three (3) with no earned income.

(2) The department may set payment levels for families earning above the federal poverty level by rule to allow for a gradual reduction in payments as earnings rise toward one hundred fifty percent (150%) of the federal poverty level.

(d)(1) Enrollment in Arkansas Work Pays Program cash assistance may be limited to three thousand (3,000) participants.

(2) If the Temporary Assistance for Needy Families Oversight Board certifies to the Governor and the Chief Fiscal Officer of the State and notifies the Legislative Council, the Senate Committee on Public Health, Welfare, and Labor, and the House Committee on Public Health, Welfare, and Labor that the action is necessary to avoid the number of families receiving Arkansas Work Pays Program cash assistance going over three thousand (3,000), it may authorize a reduction of the months for which families may receive cash assistance or other supportive services.

(3) The number of months for which families are eligible for cash assistance may be reduced in three-month increments from the statutory provision of twenty-four (24) months.

(4) Families who lose eligibility for cash assistance due to the reduction in the number of months of eligibility shall qualify for financial incentives offered to families leaving the Arkansas Work Pays Program.

(5) The board shall withdraw its reduction of the months for which families are eligible for cash assistance if the reduction is no longer necessary to maintain enrollments below three thousand (3,000) families.

(e) Families participating in the Arkansas Work Pays Program shall be eligible for the same support services and assistance as families enrolled in the Transitional Employment Assistance Program.



(f) The Department of Workforce Services shall administer a work incentive program that includes cash bonuses and other financial incentives to encourage:

(1) Transitional Employment Assistance Program recipients to leave the Transitional Employment Assistance Program and move into the Arkansas Work Pays Program;

(2) Arkansas Work Pays Program participants to stay employed for at least twenty-four (24) hours a week and meet the federal work participation rate; and

(3) Arkansas Work Pays Program participants to leave the Arkansas Work Pays Program and continue employment for at least twenty-four (24) hours per week.

(g)(1) The Department of Workforce Services shall work with local workforce offices to develop and administer services to Arkansas Work Pays Program participants designed to help them move into higher-paying jobs available in their regions.

(2) These services may include:

(A) Employment exchanges;

(B) Education and training;

(C) Work supports; and

(D) Other services designed to help Arkansas Work Pays Program participants increase their earnings and develop careers.

(3) The Department of Workforce Services may make these services available to low-income workers who are not participating in the Arkansas Work Pays Program.

(h) The Department of Workforce Services may contract with the Department of Human Services for administrative services related to eligibility and payments.

(i) The Department of Workforce Services shall make arrangements with the Department of Human Services to facilitate participants' enrollment in the Arkansas Work Pays Program after they leave the Transitional Employment Assistance Program.

(j)(1) The Department of Workforce Services shall promulgate rules establishing the Arkansas Work Pays Program.

(2) The rules shall be subject to review and recommendation by the board.

**History.** Acts 2005, No. 1705, § 19; 2007, No. 514, §§ 21, 22; 2009, No. 952, § 15.

**Amendments.** The 2009 amendment substituted “§ 20-76-113” for “§ 20-76-105(1)” in (a)(2)(B).

## **20-76-445. Career Pathways Initiative.**

(a) The General Assembly finds that:

(1) Higher education credentials are:

(A) Becoming increasingly important for the State of Arkansas to maintain a competitive workforce; and

(B) Critical for adults to qualify and obtain high-wage employment; and

(2) It is in the public interest that:

(A) Individuals improve their education credentials in order to qualify for higher-wage jobs;

(B) Eligible persons have access to postsecondary education programs that meet the specific needs of working adults;

(C) Institutions of higher education offer programs targeted to the specific workforce needs of their area within the state; and

(D) Our state provide services aimed at improving employment prospects for low-income adults.

(b)(1)(A) The Department of Workforce Services, the Department of Higher Education, and the Arkansas Workforce Investment Board shall work jointly to develop a plan for the Career Pathways Initiative.

(B) The plan shall be updated annually.

(2) The initiative shall:

(A) Increase the access of low-income parents and other individuals to education credentials that qualify them for higher-paying jobs in their local areas;

(B) Improve the preparedness of the Arkansas workforce for high skill and high-wage jobs;

(C) Develop training courses and educational credentials after consulting local employers and local workforce boards to identify appropriate job opportunities and needed skills and training to meet employers' needs;

(D) Provide resources on the basis of performance incentives, including participants:

(i) Enrolling in courses;

(ii) Completing the courses;

(iii) Obtaining jobs in the targeted job categories; and

(iv) Staying employed in the targeted job categories;

(E) Use available Temporary Assistance for Needy Families funds for participants who have custody or legal responsibility for a child under twenty-one (21) years of age and whose family income is less than two hundred fifty percent (250%) of the federal poverty level; and

(F) Incorporate the existing Career Pathways Program.

(c) The initiative plan shall be subject to review, recommendation, and approval by the Temporary Assistance for Needy Families Oversight Board.

(d) Under the initiative, the Department of Higher Education shall contract to provide education and training that will result in job training certificates or higher education degrees for Transitional Employment Assistance Program participants and other low-income adults with:

(1) State agencies;

(2) Two-year colleges;

(3) Local governments; or

(4) Private or community organizations.



(e)(1) The initiative plan shall specify procedures and requirements for applications for entry into programs under subsection (d) of this section.

(2) Applications shall be made to the Department of Higher Education.

(f) The Department of Higher Education shall determine which two-year college proposals are funded under the initiative.

(g) Temporary Assistance for Needy Families funds may be combined with other federal, state, and local funds in ways consistent with federal laws and regulations.

**History.** Acts 2005, No. 1705, § 19;  
2007, No. 514, § 23.

### **20-76-446. Community Investment Initiative.**

(a)(1) There is created the Community Investment Initiative.

(2) The Department of Workforce Services shall develop the initiative.

(b) The department shall contract with private or community organizations, including faith-based organizations, to offer services and support to parents, children, and youth in their communities.

(c) The initiative may fund programs for the following purposes:

(1) Improving outcomes for youth, including, but not limited to:

(A) Academic achievement;

(B) Job skills;

(C) Civic participation and community involvement; and

(D) Reducing risky behaviors such as sexual activities, drug use, and criminal behavior;

(2) Improving parenting and family functioning through services and support to parents, children, and to families;

(3) Improving marriage and relationship skills among youth and engaged and married couples;

(4) Improving the financial and emotional connections of noncustodial parents to their children through fatherhood programs;

(5) Improving the employment skills and family connections of parents who leave state jails and prisons;

(6) Providing supportive services to child-only cases in the Transitional Employment Assistance Program; and

(7) Other purposes allowable under the federal Temporary Assistance for Needy Families program.

(d)(1) The department shall authorize contracts with state agencies or community organizations to provide training and capacity building services to organizations eligible to apply for initiative funds.

(2) Contracts may be let for the following purposes:

(A) Assisting in the development of proposals to be funded through the initiative;

(B) Preparing organizations for the fiscal responsibilities involved in receiving and spending state and federal funds; and

(C) Improving the provision of services by contractors receiving funds from the initiative.

(e) Use of Temporary Assistance for Needy Families funds shall be subject to appropriations by the General Assembly for the Community Investment Initiative.

(f) Contracts shall include performance-based payments keyed to participation in services and specified outcomes.

(g) Temporary Assistance for Needy Families may be combined with other state, federal, and other funds in ways consistent with federal laws and rules.

**History.** Acts 2005, No. 1705, § 19;  
2007, No. 514, § 24.

## SUBCHAPTER 5 — ARKANSAS RX PROGRAM

### SECTION.

20-76-501 — 20-76-515. [Repealed.]

### 20-76-501 — 20-76-515. [Repealed.]

**Publisher's Notes.** These sections, concerning the Arkansas Rx Program, were repealed by Acts 2013, No. 1145, § 5. They derived from the following sources:

20-76-501. 2005, No. 538, § 1.  
20-76-502. 2005, No. 538, § 1.  
20-76-503. 2005, No. 538, § 1.  
20-76-504. 2005, No. 538, § 1.  
20-76-505. 2005, No. 538, § 1.  
20-76-506. 2005, No. 538, § 1.

20-76-507. 2005, No. 538, § 1.  
20-76-508. 2005, No. 538, § 1.  
20-76-509. 2005, No. 538, § 1.  
20-76-510. 2005, No. 538, § 1.  
20-76-511. 2005, No. 538, § 1.  
20-76-512. 2005, No. 538, § 1.  
20-76-513. 2005, No. 538, § 1.  
20-76-514. 2005, No. 538, § 1.  
20-76-515. 2005, No. 538, § 1.

## SUBCHAPTER 6 — COMMUNITY SERVICES OVERSIGHT AND PLANNING COUNCIL

### SECTION.

20-76-601. Community Services Oversight and Planning Council — Created — Duty.  
20-76-602. Community Services Oversight and Planning Council — Membership.

### SECTION.

20-76-603. Powers and duties.

### 20-76-601. Community Services Oversight and Planning Council — Created — Duty.

(a) There is created the Community Services Oversight and Planning Council.

(b) The Community Services Oversight and Planning Council shall serve in an advisory capacity to the Legislative Council and to the Joint Budget Committee.

**History.** Acts 2005, No. 1670, § 1.



**20-76-602. Community Services Oversight and Planning Council — Membership.**

(a) The Community Services Oversight and Planning Council shall be composed of the following eleven (11) members appointed by the Legislative Council as follows:

(1) Three (3) members of the Senate recommended by the President Pro Tempore of the Senate;

(2) Three (3) members of the House of Representatives recommended by the Speaker of the House of Representatives; and

(3) Five (5) members to be appointed by the House of Representatives and Senate cochair of the Legislative Council as follows:

(A) Two (2) providers of community-based developmental disability services licensed by the Division of Developmental Disabilities Services of the Department of Human Services appointed as follows:

(i) One (1) member to represent the Developmental Disabilities Provider Association from a list provided by the association; and

(ii) One (1) member to represent the Community Developmental Disabilities Provider Network from a list provided by the network;

(B) One (1) member who is a provider of community-based services for individuals with behavioral health needs from a list provided by the Mental Health Council of Arkansas;

(C) One (1) member who is a provider of community-based services for youth from a list provided by the Arkansas Youth Services Providers Association; and

(D) One (1) member who is a provider of community-based services to the aging from a list provided by the Arkansas Association of Area Agencies on Aging.

(b) The members of the Community Services Oversight and Planning Council shall serve two-year terms and may be reappointed.

(c)(1) The House of Representatives and Senate cochair of the Legislative Council shall call the first meeting of the Community Services Oversight and Planning Council within sixty (60) days of August 12, 2005.

(2) The House of Representatives and Senate cochair of the Legislative Council shall appoint a chair and vice chair from among the members of the Community Services Oversight and Planning Council.

(d) The Community Services Oversight and Planning Council shall:

(1) Set the date, place, and time of meetings as necessary to perform its duties; and

(2)(A) Provide information regarding scheduled meetings to the Bureau of Legislative Research.

(B) The bureau shall publish the information on the bureau's website.

(e) The bureau shall provide coordination and staff support to the Community Services Oversight and Planning Council.

**20-76-603. Powers and duties.**

(a)(1) The Community Services Oversight and Planning Council shall gather information and data regarding the community-based service needs of citizens with developmental disabilities, behavioral health service needs, aging services needs, and youth services needs that are to be delivered by community-based programs operated by licensed providers through contractual relationships with the State of Arkansas.

(2) The Department of Human Services and service providers operating under contract with the State of Arkansas shall provide to the Community Services Oversight and Planning Council on request information regarding service needs and funding to meet the needs of individuals through community-based options.

(3) This information and data shall be the basis for recommendations for community-based service budget appropriations, special language, and funding for the community-based programs.

(b) The Community Services Oversight and Planning Council shall report at least quarterly to the Legislative Council and the Joint Budget Committee.

(c) In deliberations concerning the department's proposed budget, the Legislative Council or the Joint Budget Committee shall take into consideration the recommendations of the Community Services Oversight and Planning Council.

**History.** Acts 2005, No. 1670, § 1.

**CHAPTER 77****MEDICAL ASSISTANCE****SUBCHAPTER.**

1. GENERAL PROVISIONS.
  3. THIRD-PARTY LIABILITY.
  5. EYE CARE.
  8. HOME INTRAVENOUS DRUG THERAPY SERVICES.
  9. MEDICAID FRAUD FALSE CLAIMS ACT.
  11. ARKIDS FIRST PROGRAM ACT.
  12. MEDICAID PROGRAM FOR LOW-INCOME DISABLED WORKING PERSONS.
  15. COMMUNITY-BASED HEALTH CARE ACCESS PROGRAMS.
  16. ARKANSAS YOUTH SUICIDE PREVENTION ACT.
  17. MEDICAID FAIRNESS ACT.
  18. ARKANSAS LONG-TERM CARE PARTNERSHIP PROGRAM.
  19. ASSESSMENT FEE ON HOSPITALS TO IMPROVE HEALTH CARE ACCESS.
  20. ARKIDS FIRST MEDICAL ASSISTANCE PROGRAMS ENROLLMENT AND RETENTION IMPROVEMENT PROGRAM.
  21. MEDICAID ELIGIBILITY VERIFICATION SYSTEM.
  22. HEALTHCARE QUALITY AND PAYMENT POLICY ADVISORY COMMITTEE.
  23. HOME CAREGIVER TRAINING.
  24. HEALTH CARE INDEPENDENCE ACT OF 2013.
  25. OFFICE OF MEDICAID INSPECTOR GENERAL.
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**A.C.R.C. Notes.** Acts 2003, No. 767, § 1, provided: “(a) The House and Senate Interim Committees on Public Health, Welfare, and Labor shall study the problems that Arkansas families face in gaining and retaining eligibility for Medicaid assistance for children who need continuous medical health care, but are not ventilator dependent.

“(b) The study shall include, but not be limited to:

“(1) The Medicaid eligibility criteria for disabled children who are not dependent on a ventilator;

“(2) The need for increased numbers of and improved compensation for private duty nurses;

“(3) The creation of a Private Duty Eligibility Committee within the Division of Developmental Disabilities Services of the Department of Human Services to:

“(A) Visit the homes of families with disabled children;

“(B) Study the impact on families of coping with a disabled child or children in the home;

“(C) Develop alternative approaches to caring for disabled children in the home; and

“(D) Recommend changes in the eligibility and utilization review criteria and processes concerning in-home care for disabled children.”

Acts 2011, No. 1068, § 13, provided: “STATE PLAN. The State Plan must include the provision of EPSDT services as those services are defined in §1396d(r). See §§ 1396a(a)(10)(A), 1396d(a)(4)(B); see also 1396a(a)(43). Section 1396d(r) lists in detail the screening services, vision services, dental services, and hearing services that the State Plan must expressly include, but with regard to treatment services, it states that EPSDT means ‘[s]uch other necessary health care, diagnostic services, treatment, and other measures described in subsection (a) of this section to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan.’ 42 U.S.C. § 1396d(r)(5) (emphasis added). Reading §1396a, § 1396d(a), and § 1396d(r) together, we believe that the State Plan need not specifically list every treatment service conceivably available under the EPSDT mandate.

“The State Plan, however, must pay part or all of the cost of treatments to ameliorate conditions discovered by the screening process when those treatments meet the definitions set forth in § 1396a. See §1396d(r)(5); see also §§1396a(a)(10), 1396a (a)(43), and 1396d(a)(4)(B). The Arkansas State Plan states that the ‘State will provide other health care described in [42 U.S.C. 1396d(a)] that is found to be medically necessary to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, even when such health care is not otherwise covered under the State Plan.’ See State Plan Under Title XIX of the Social Security Act Medical Assistance Program, State Of Arkansas at §4.b. This provision Meets the EPSDT mandate of the Medicaid Act.

“We affirm the district court’s decision to the extent that it holds that a Medicaid-Eligible individual has a federal right to early intervention day treatment when a physician recommends such treatment. Section 1396d(r)(5) states that EPSDT includes any treatments or measures outlined in §1396d(a). There are twenty-seven sub-parts to §1396d(a), and we find that sub-part (a)(13), in particular, when read with the other sections of the Medicaid Act listed above, mandates that early intervention day treatment be provided when it is prescribed by a physician. See 42 U.S.C. §1396d(a)(13) (defining medical assistance reimbursable by Medicaid as ‘other diagnostic, screening, preventive, and rehabilitative services, including any medical or remedial services recommended by a physician...for the maximum reduction of physical and mental disability and restoration of an individual to the best possible functional level’). Therefore, after CHMS clinic staff perform a diagnostic evaluation of an eligible child, if the CHMS physician prescribes early intervention day treatment as a service that would lead to the maximum reduction of medical and physical disabilities and restoration of the child to his or her best possible functional level, the Arkansas State Plan must reimburse the treatment. Because CHMS clinics are the only providers of early intervention day treatment, Arkansas must reimburse those clinics.”

Acts 2012, No. 250, § 13, provided: “STATE PLAN. The State Plan must in-

clude the provision of EPSDT services as those services are defined in §1396d(r). See §§ 1396a(a)(10)(A), 1396d(a)(4)(B); see also 1396a(a)(43). Section 1396d(r) lists in detail the screening services, vision services, dental services, and hearing services that the State Plan must expressly include, but with regard to treatment services, it states that EPSDT means “[s]uch other necessary health care, diagnostic services, treatment, and other measures described in subsection (a) of this section to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan.” 42 U.S.C. § 1396d(r)(5) (emphasis added). Reading §1396a, § 1396d(a), and § 1396d(r) together, we believe that the State Plan need not specifically list every treatment service conceivably available under the EPSDT mandate.

“The State Plan, however, must pay part or all of the cost of treatments to ameliorate conditions discovered by the screening process when those treatments meet the definitions set forth in § 1396a. See §1396d(r)(5); see also §§1396a(a)(10), 1396a(a)(43), and 1396d(a)(4)(B). The Arkansas State Plan states that the ‘State will provide other health care described in [42 U.S.C. 1396d(a)] that is found to be medically necessary to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, even when such health care is not otherwise covered under the State Plan.’ See State Plan Under Title XIX of the Social Security Act Medical Assistance Program, State Of Arkansas at §4.b. This provision Meets the EPSDT mandate of the Medicaid Act.

“We affirm the district court’s decision to the extent that it holds that a Medicaid-Eligible individual has a federal right to early intervention day treatment when a physician recommends such treatment. Section 1396d(r)(5) states that EPSDT includes any treatments or measures outlined in §1396d(a). There are twenty-seven sub-parts to §1396d(a), and we find that sub-part (a)(13), in particular, when read with the other sections of the Medicaid Act listed above, mandates that early intervention day treatment be provided when it is prescribed by a physician. See 42 U.S.C. §1396d(a)(13) (defining medical

assistance reimbursable by Medicaid as ‘other diagnostic, screening, preventive, and rehabilitative services, including any medical or remedial services recommended by a physician...for the maximum reduction of physical and mental disability and restoration of an individual to the best possible functional level’). Therefore, after CHMS clinic staff perform a diagnostic evaluation of an eligible child, if the CHMS physician prescribes early intervention day treatment as a service that would lead to the maximum reduction of medical and physical disabilities and restoration of the child to his or her best possible functional level, the Arkansas State Plan must reimburse the treatment. Because CHMS clinics are the only providers of early intervention day treatment, Arkansas must reimburse those clinics.”

Acts 2013, No. 1449, § 11, provided: “MEDICAID PRIMARY CARE CASE MANAGEMENT PROGRAM.

“(a) The General Assembly finds that:

“(1) The Arkansas Delta is an area that is medically underserved and has some of the worst health outcomes in our state, with a large number of recipients who are in the top quartile of costs;

“(2)(A) There has been much success in other states, particularly in the Louisiana Delta with improvements in health outcomes and saving money through the use of an intensive care-coordination, shared-savings model of care.

“(B) This success has come through contracting with private companies that specialize in working with those individuals who meet certain criteria and are at a minimum in the top quartile of costs to the Medicaid program;

“(3) Medicaid is one of the largest percentage expenditures of Arkansas tax dollars, and there is a need for reforming approaches to the use of these dollars; and

“(4) The approach created in this section to dealing with this population has never been implemented in Arkansas.

“(b)(1)(A) The Department of Human Services shall contract with an experienced vendor to implement a two-year Medicaid Primary Care Case Management shared-savings pilot program in the Arkansas Delta region to begin January 1, 2014.

“(B) The department shall give preference to a vendor that:



"(i) Demonstrates experience with the type of model established under this section in the type of geographic area specified in subsection (e) of this section;

"(ii) Has demonstrated customer satisfaction as documented through independent Consumer Assessment of Healthcare Providers and Systems survey; and

"(iii) Maintains a Utilization Review Accreditation Commission accreditation for its Health Utilization Management and Case Management programs.

"(2) The pilot program shall encompass a minimum of five thousand (5,000) recipients who:

"(A) Are not currently in the Arkansas Patient-Centered Medical Home Program, the federal Comprehensive Primary Care Initiative, or a similar home health program;

"(B)(i) Have catastrophic or chronic conditions as defined by the Johns Hopkins Adjusted Clinical Groups System; or

"(ii) Are women with a history of past high-risk pregnancies, poor birth outcomes or preterm deliveries; and

"(C) Whose estimated costs are in the top quartile for their defined population.

"(c) The vendor shall recruit an adequate number of primary care clinics to initiate the program.

"(d) The Medicaid Primary Care Case Management shared savings pilot program shall exclude the Alternatives for Persons with Disabilities, the Division of Developmental Disabilities Services Alternative Community Services, Elder Choices, Living Choices Assisted Living waivers, and members of the Program of All-Inclusive Care for the Elderly.

"(e) The Medicaid Primary Care Case Management program shared savings pilot program shall include without limitation the following Arkansas delta counties:

- "(1) Arkansas;
- "(2) Ashley;
- "(3) Baxter;
- "(4) Bradley;
- "(5) Calhoun;
- "(6) Chicot;
- "(7) Clay;
- "(8) Cleveland;
- "(9) Crittenden;
- "(10) Cross;
- "(11) Dallas;
- "(12) Desha;
- "(13) Drew;

"(14) Fulton;

"(15) Grant;

"(16) Greene;

"(17) Independence;

"(18) Izard;

"(19) Jackson;

"(20) Jefferson;

"(21) Lawrence;

"(22) Lee;

"(23) Lincoln;

"(24) Lonoke;

"(25) Marion;

"(26) Mississippi;

"(27) Monroe;

"(28) Ouachita;

"(29) Phillips;

"(30) Poinsett;

"(31) Prairie;

"(32) Randolph;

"(33) Searcy;

"(34) Sharp;

"(35) St. Francis;

"(36) Stone;

"(37) Union;

"(38) Van Buren; and

"(39) Woodruff.

"(f) The department shall require that a contracting vendor generate savings in comparison to a risk-adjusted Arkansas Fee-For-Service benchmark.

"(g) The per-member monthly fee paid to the vendor shall not decrease the current primary care case management fee paid to the primary care providers.

"(h)(1) Savings realized under the Medicaid Primary Care Case Management program shall be shared:

"(A) Thirty-four percent (34%) with the department; and

"(B)(i) Sixty-six percent (66%) with the Medicaid Primary Care Case Management shared-savings pilot program vendor up to a maximum sharing cap of five percent (5%) of the total cost of administrative and health service expenditures as defined by the Centers for Medicare and Medicaid Service.

"(ii) Further, fifty percent (50%) of savings received by the vendor shall be shared with eligible contracted network primary care providers based upon meeting agreed upon performance standards.

"(2) Twenty five percent (25%) of the Medicaid Primary Care Case Management shared-savings pilot program vendor's administrative per member per month fee shall be at risk and shall be

paid back to the state if savings are not realized.

“(i)(1) After the Medicaid Primary Care Case Management shared-savings pilot program has operated for fifteen (15) months, the department shall utilize an agreed upon savings algorithm to calculate savings based on the first twelve (12) months of operations, allowing three (3) months of run-out.

“(2)(A) Savings shall be disbursed within thirty (30) calendar days of final calculation.

“(B) After the initial year of operation, savings shall be calculated on a quarterly basis.

“(j) This section does not conflict with or reduce the Medicaid hospital access payments under section § 20-77-1901 et seq.

“(k)(1) This section does not require a physician to participate in the pilot program created under this section.

“(2) A physician has the right to refuse to contract under the pilot program created under this section or to terminate the contract at any time without penalty.

“(l) If requested, the vendor shall agree to support any contracted physician in meeting the requirements of the Arkansas Patient-Centered Medicaid Home model.

“The provisions of this section shall be in effect only from July 1, 2013 through June 30, 2014.”

Acts 2013, No. 1453, § [1], provided: **MEDICAID PRIMARY CARE CASE MANAGEMENT PROGRAM.**

“(a) The General Assembly finds that:

“(1) The Arkansas Delta is an area that is medically underserved and has some of the worst health outcomes in our state, with a large number of recipients who are in the top quartile of costs;

“(2)(A) There has been much success in other states, particularly in the Louisiana Delta with improvements in health outcomes and saving money through the use of an intensive care-coordination, shared-savings model of care.

“(B) This success has come through contracting with private companies that specialize in working with those individuals who meet certain criteria and are at a minimum in the top quartile of costs to the Medicaid program;

“(3) Medicaid is one of the largest percentage expenditures of Arkansas tax dol-

lars, and there is a need for reforming approaches to the use of these dollars; and

“(4) The approach created in this section to dealing with this population has never been implemented in Arkansas.

“(b)(1) The Department of Human Services shall contract with an experienced vendor to implement a two-year Medicaid Primary Care Case Management shared-savings pilot program in the Arkansas Delta region to begin January 1, 2014.

“(2) The pilot program shall encompass a minimum of five thousand (5,000) recipients who:

“(A) Are not currently in the Arkansas Patient-Centered Medical Home Program, the federal Comprehensive Primary Care Initiative, or a similar homehealth program;

“(B)(i) Have catastrophic or chronic conditions as defined by the Johns Hopkins Adjusted Clinical Groups System; or

“(ii) Are women with a history of past high-risk pregnancies, poor birth outcomes or preterm deliveries; and

“(C) Whose estimated costs are in the top quartile for their defined population.

“(c) The vendor shall recruit an adequate number of primary care clinics to initiate the program.

“(d) The Medicaid Primary Care Case Management shared savings pilot program shall exclude the Alternatives for Persons with Disabilities, the Division of Developmental Disabilities Services Alternative Community Services, Elder Choices, Living Choices Assisted Living waivers, and members of the Program of All-Inclusive Care for the Elderly.

“(e) The Medicaid Primary Care Case Management program shared savings pilot program shall include without limitation the following Arkansas delta counties:

“(1) Arkansas;

“(2) Ashley;

“(3) Baxter;

“(4) Bradley;

“(5) Calhoun;

“(6) Chicot;

“(7) Clay;

“(8) Cleveland;

“(9) Crittenden;

“(10) Cross;

“(11) Dallas;

“(12) Desha;

“(13) Drew;

“(14) Fulton;



- "(15) Grant;
- "(16) Greene;
- "(17) Independence;
- "(18) Izard;
- "(19) Jackson;
- "(20) Jefferson;
- "(21) Lawrence;
- "(22) Lee;
- "(23) Lincoln;
- "(24) Lonoke;
- "(25) Marion;
- "(26) Mississippi;
- "(27) Monroe;
- "(28) Ouachita;
- "(29) Phillips;
- "(30) Poinsett;
- "(31) Prairie;
- "(32) Randolph;
- "(33) Searcy;
- "(34) Sharp;
- "(35) St. Francis;
- "(36) Stone;
- "(37) Union;
- "(38) Van Buren; and
- "(39) Woodruff.

"(f) The department shall require that a contracting vendor generate savings in comparison to a risk-adjusted Arkansas Fee-For-Service benchmark.

"(g) The per-member monthly fee paid to the vendor shall not decrease the current primary care case management fee paid to the primary care providers.

"(h)(1) Savings realized under the Medicaid Primary Care Case Management program shall be shared:

"(A) Thirty-four percent (34%) with the department; and

"(B)(i) Sixty-six percent (66%) with the Medicaid Primary Care Case Management shared-savings pilot program vendor up to a maximum sharing cap of five percent (5%) of the total cost of administrative and health service expenditures as defined by the Centers for Medicare and Medicaid Service.

"(ii) Further, fifty percent (50%) of savings received by the vendor shall be shared with eligible contracted network primary care providers based upon meeting agreed upon performance standards.

"(2) Twenty five percent (25%) of the Medicaid Primary Care Case Management shared-savings pilot program vendor's administrative per member per month fee shall be at risk and shall be paid back to the state if savings are not realized.

"(i)(1) After the Medicaid Primary Care Case Management shared-savings pilot program has operated for fifteen (15) months, the department shall utilize an agreed upon savings algorithm to calculate savings based on the first twelve (12) months of operations, allowing three (3) months of run-out.

"(2)(A) Savings shall be disbursed within thirty (30) calendar days of final calculation.

"(B) After the initial year of operation, savings shall be calculated on a quarterly basis.

"(j) This section does not conflict with or reduce the Medicaid hospital access payments under section § 20-77-1901 et seq.

"(k)(1) This section does not require a physician to participate in the pilot program created under this section.

"(2) A physician has the right to refuse to contract under the pilot program created under this section or to terminate the contract at any time without penalty.

"(l) If requested, the vendor shall agree to support any contracted physician in meeting the requirements of the Arkansas Patient-Centered Medicaid Home model."

Acts 2013, No. 1496, § 16, provided: "STATE PLAN. The State Plan must include the provision of EPSDT services as those services are defined in §1396d(r). See §§ 1396a(a)(10)(A), 1396d(a)(4)(B); see also 1396a(a)(43). Section 1396d(r) lists in detail the screening services, vision services, dental services, and hearing services that the State Plan must expressly include, but with regard to treatment services, it states that EPSDT means '[s]uch other necessary health care, diagnostic services, treatment, and other measures described in subsection (a) of this section to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan.' 42 U.S.C. § 1396d(r)(5) (emphasis added). Reading §1396a, § 1396d(a), and § 1396d(r) together, we believe that the State Plan need not specifically list every treatment service conceivably available under the EPSDT mandate.

"The State Plan, however, must pay part or all of the cost of treatments to ameliorate conditions discovered by the screening process when those treatments

meet the definitions set forth in § 1396a. See §1396d(r)(5); see also §§1396a(a)(10), 1396a (a)(43), and 1396d(a)(4)(B). The Arkansas State Plan states that the 'State will provide other health care described in [42 U.S.C. 1396d(a)] that is found to be medically necessary to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, even when such health care is not otherwise covered under the State Plan.' See State Plan Under Title XIX of the Social Security Act Medical Assistance Program, State Of Arkansas at §4.b. This provision Meets the EPSDT mandate of the Medicaid Act.

"We affirm the district court's decision to the extent that it holds that a Medicaid-Eligible individual has a federal right to early intervention day treatment when a physician recommends such treatment. Section 1396d(r)(5) states that EPSDT includes any treatments or measures outlined in §1396d(a). There are twenty-seven sub-parts to §1396d(a), and we find that sub-part (a)(13), in particular, when read with the other sections of the Medicaid Act listed above, mandates that early intervention day treatment be provided when it is prescribed by a physician. See 42 U.S.C. §1396d(a)(13) (defining medical assistance reimbursable by Medicaid as 'other diagnostic, screening, preventive, and rehabilitative services, including any medical or remedial services recommended by a physician...for the maximum reduction of physical and mental disability and restoration of an individual to the best possible functional level'). Therefore, after CHMS clinic staff perform a diagnostic evaluation of an eligible child, if the CHMS physician prescribes early intervention day treatment as a service that would lead to the maximum reduction of medical and physical disabilities and restoration of the child to his or her best possible functional level, the Arkansas State Plan must reimburse the treatment. Because CHMS clinics are the only providers of early intervention day treatment, Arkansas must reimburse those clinics."

Acts 2013, No. 1496, § 17, provided: "MEDICAL SERVICES — STATE MEDICAID PROGRAM/PERSONAL CARE PROGRAM.

"(a) It is the legislative intent that the Department of Human Services in its ad-

ministration of the Arkansas Medicaid Program set forth Medicaid provider participation requirements for 'personal care providers' that will insure sufficient available providers to meet the required needs of all eligible recipients, to include insuring available in home services twenty-four (24) hours a day and seven (7) days a week for personal care.

"(b) For the purposes of this section, 'private care agencies' are defined as those providers licensed by the Department of Labor, certified as ElderChoices Providers and who furnish in home staffing services for respite, chore services, and homemaker services, and are covered by liability insurance of not less than one million dollars (\$1,000,000) covering their employees and independent contractors while they are engaged in providing services, such as personal care, respite, chore services, and homemaker services.

"(c) The purpose of this section is to allow the private care agencies defined herein to be eligible to provide Medicaid reimbursed personal care services seven (7) days a week, and does not supercede Department of Human Services rules establishing monthly benefit limits and prior authorization requirements.

"(d) The availability of providers shall not require the Department of Human Services to reimburse for twenty-four (24) hours per day of personal care services.

"(e) The Arkansas Department of Human Services, Medical Services Division shall take such action as required by the Centers for Medicare and Medicaid Services to amend the Arkansas Medicaid manual to include, private care agencies, as qualified entities to provide Medicaid reimbursed personal care services.

"(f) The private care agencies shall comply with rules and regulations promulgated by the Arkansas Department of Health which shall establish a separate licensure category for the private care agencies for the provision of Medicaid reimbursable personal care services seven (7) days a week.

"(g) The Arkansas Department of Health shall supervise the conduct of the personal care agencies defined herein.

"(h) The purpose of this section is to insure the care provided by the private care agencies, is consistent with the rules and regulations of the Arkansas Department of Health.



"The provisions of this section shall be in effect only from July 1, 2013 through June 30, 2014."

Acts 2013, No. 1496, § 18, provided: "REVIEW OF RULES IMPACTING STATE MEDICAID COSTS.

"(a) In light of the rapidly rising potential costs to the State attributable to the Medicaid program and the importance of Medicaid expenditures to the health and welfare of the citizens of this State, the General Assembly finds it desirable to exercise more thorough review of future proposed changes to rules that might impact those costs or expenditures.

"(b) As used in this section, 'rule impacting state Medicaid costs' means a proposed rule, as defined by § 25-15-202(8), or a proposed amendment to an existing rule, as defined by § 25-15-202(8), that would, if adopted, adjust Medicaid reimbursement rates, Medicaid eligibility criteria, or Medicaid benefits, including without limitation a proposed rule or a proposed amendment to an existing rule seeking to accomplish the following:

"(1) Reduce the number of individuals covered by Arkansas Medicaid;

"(2) Limit the types of services covered by Arkansas Medicaid;

"(3) Reduce the utilization of services covered by Arkansas Medicaid;

"(4) Reduce provider reimbursement;

"(5) Increase consumer cost-sharing;

"(6) Reduce the cost of administering Arkansas Medicaid;

"(7) Increase Arkansas Medicaid revenues;

"(8) Reduce fraud and abuse in the Arkansas Medicaid program;

"(9) Change any of the methodologies used for reimbursement of providers;

"(10) Seek a new waiver or modification of an existing waiver of any provision under Medicaid, Title XIX, of the Social Security Act, including a waiver that would allow a demonstration project;

"(11) Participate or seek to participate in Social Security Act Section 1115(a)(1) waiver authority that would allow operation of a demonstration project or program;

"(12) Participate or seek to participate in a Social Security Act Section 1115(a)(2) request for the Secretary of the Department of Health and Human Services to provide federal financial participation for

costs associated with a demonstration project or program;

"(13) Implement managed care provisions under Section 1932 of Medicaid, Title XIX of the Social Security Act; or

"(14) Participate or seek to participate in the Centers for Medicare and Medicaid Services Innovation projects or programs.

"(c)(1) In addition to filing requirements under the Arkansas Administrative Procedure Act, § 25-15-201 et seq., and § 10-3-309, the Department of Human Services shall, at least thirty (30) days before the expiration of the period for public comment, file a proposed rule impacting state Medicaid costs or a proposed amendment to an existing rule impacting state Medicaid costs with the Senate Interim Committee on Public Health, Welfare, and Labor and the House Interim Committee on Public Health, Welfare, and Labor, or, when the General Assembly is in session, with the Senate Committee on Public Health, Welfare, and Labor and the House Committee on Public Health, Welfare and Labor.

"(2) Any review of the proposed rule or proposed amendment to an existing rule by the Senate and House Interim Committees on Public Health, Welfare and Labor or the Senate and House Committees on Public Health, Welfare, and Labor shall occur within forty-five (45) days of the date the proposed rule or proposed amendment to an existing rule is filed with the committees.

"(d)(1) If adopting an emergency rule impacting state Medicaid costs, in addition to the filing requirements under the Arkansas Administrative Procedure Act, § 25-15-201 et seq. and § 10-3-309, the Department of Human Services shall notify the Speaker of the House of Representatives, the President Pro Tempore of the Senate, the chair of the Senate Committee on Public Health, Welfare, and Labor, and the chair of the House Committee on Public Health, Welfare and Labor of the emergency rule and provide each of them a copy of the rule within five (5) business days of adopting the rule.

"(2) Any review of the emergency rule by the Senate and House Interim Committees on Public Health, Welfare and Labor or the Senate and House Committees on Public Health, Welfare, and Labor shall occur within forty-five (45) days of the

date the emergency rule is provided to the chairs.

“(e)(1) The Joint Budget Committee may review a rule impacting state Medicaid costs during a regular, fiscal, or special session of the General Assembly.

“(2) Actions taken by the Joint Budget Committee when reviewing a rule impacting state Medicaid costs shall have the

same effect as actions taken by the Legislative Council under § 10-3-309.

“(3) If the Joint Budget Committee reviews a rule impacting state Medicaid costs, it shall file a report of its actions with the Legislative Council as soon as practicable.

“(f) This section expires on June 30, 2014.”

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## SUBCHAPTER 1 — GENERAL PROVISIONS

### SECTION.

- 20-77-102. Program for long-term care facility care.
- 20-77-107. Program for indigent medical care — Rules and regulations.
- 20-77-111. Data reports.
- 20-77-116 — 20-77-118. [Repealed.]
- 20-77-120. Medicaid waiver for home and community-based care.
- 20-77-121. Adverse decisions — Notice — Rights.
- 20-77-122. Survey agency for psychiatric residential treatment facilities of children.
- 20-77-123. Drugs for asthma and other respiratory diseases.

### SECTION.

- 20-77-124. Medicaid waiver for autism.
- 20-77-125. Contingency fee audits prohibited.
- 20-77-126. Relation to Arkansas Pharmacy Audit Bill of Rights.
- 20-77-127. Eligibility for long-term care.
- 20-77-128. In-home caregiver drug tests and criminal background checks.
- 20-77-129. Ambulatory surgery centers — Medicaid reimbursement.
- 20-77-130. Medicaid provider tax returns.

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**Effective Dates.** Acts 2003, No. 1473, § 74: July 1, 2003. Emergency clause provided: “It is found and determined by the General Assembly of the State of Arkansas that this act includes technical corrects to Act 923 of 2003 which establishes the classification and compensation levels of state employees covered by the provisions of the Uniform Classification and Compensation Act; that Act 923 of 2003 will become effective on July 1, 2003; and that to avoid confusion this act must also [sic] effective on July 1, 2003. Therefore, an emergency is declared to exist and this act being necessary for the preservation of the public peace, health, and safety shall become effective on July 1, 2003.”

Acts 2013, No. 1109, § 3: Apr. 11, 2013. Emergency clause provided: “It is found and determined by the General Assembly of the State of Arkansas that Medicaid

providers are subject to an increasing number of contracted entities performing provider audits and that such entities should be compensated based on the volume of work that they do and not be given an incentive to identify more overpayments in order to increase the payments they receive, and that it is imperative that changes be made in state law to remedy this problem. Therefore, an emergency is declared to exist and this act being immediately necessary for the preservation of the public peace, health, and safety shall become effective on: (1) The date of its approval by the Governor; (2) If the bill is neither approved nor vetoed by the Governor, the expiration of the period of time during which the Governor may veto the bill; or (3) If the bill is vetoed by the Governor and the veto is overridden, the date the last house overrides the veto.”



20-77-101. Cost-sharing charges for medically indigent.

RESEARCH REFERENCES

Ark. L. Rev. An Accident Waiting to Happen: Arkansas Department of Health and Human Services v. Ahlborn Exposes Inequities in Medical Benefits Legislation, 60 Ark. L. Rev. 533.

CASE NOTES

ANALYSIS

Eligibility.  
Public Policy and Trusts.

Eligibility.

Department of Human Services prevailed in its argument that the applicant's daughter sold the applicant a life estate in the daughter's home and spent thousands of dollars of the applicant's money to improve the home to artificially impoverish the applicant so that the applicant would be eligible for Medicaid. *Groce v. Dir.*, 82 Ark. App. 447, 117 S.W.3d 618 (2003).

Public Policy and Trusts.

Trustee intended to modify the trust in order to qualify a beneficiary for public benefits; because impoverishing the ben-

eficiary in order to qualify her would make the trust provisions void, the modified provisions would have been void on grounds of public policy, and the trial court's denial of the modification motion was that the purpose for modifying the trust would be defeated. *In re Ruby G. Owen Trust*, 2012 Ark. App. 381, — S.W.3d — (2012).

Trial court considered case law from other jurisdictions that permitted the modification the trustee requested in this case, in order to qualify a beneficiary for public benefits, but the trial court did not find that the modification was permissible under public policy and Arkansas law; the court was not left with a firm conviction that a mistake was committed. *In re Ruby G. Owen Trust*, 2012 Ark. App. 381, — S.W.3d — (2012).

20-77-102. Program for long-term care facility care.

(a) The appropriate division of the Department of Human Services is authorized to establish a program to provide for long-term care facility care for all residents of this state who are found to be qualified for and in need of long-term care facility care, as provided in this section.

(b) The program shall consist of:

(1) Long-term care facility care for those persons eligible to receive medical care benefits under title XIX of the Social Security Act in accordance with federal and state regulations promulgated therefor, within the maximum limitations provided under federal law or regulation for federal reimbursement for long-term care facility care under title XIX of the Social Security Act; and

(2) A program of state financial assistance for long-term care facility care for persons who are not eligible for medical care benefits under title XIX of the Social Security Act to the extent that the cost of the class of long-term care facility care for which the person is determined to be qualified exceeds the ability of the person to pay for the care.

(c)(1) However, the deputy director of the appropriate division of the department shall, in establishing the level of payment for services and benefits for long-term care facility care to be provided under the provisions of this section, promulgate appropriate rules and regulations

to limit the cost of services to the State of Arkansas to funds available or estimated to be available to the appropriate division for that purpose during each fiscal year.

(2) The regulations promulgated by the deputy director shall provide that all persons eligible within each class of eligibility shall receive equal consideration for benefits.

(3) The deputy director of the appropriate division of the department is authorized to promulgate such additional rules and regulations as deemed to be necessary to prevent abuse of benefits under this section, yet make available to the residents of this state who are eligible the full benefits of this section within the limitation of funds available therefor.

(d) The Director of the Department of Human Services, with the approval of the Governor and after obtaining the advice of the Legislative Council, may provide for an expanded comprehensive program of long-term care facility care for residents of this state if he or she deems the program advisable or appropriate in order to take advantage of expanded federal programs or participation therein, within the limitation of funds that may be available to the department therefor.

(e) To the extent not prohibited by federal law or regulation, the department shall promulgate rules concerning prior authorization for Medicaid ElderChoices, a community-based service, that are identical to those in effect for nursing homes on July 16, 2003.

**History.** Acts 1965 (2nd Ex. Sess.), No. 14, § 7; 1977, No. 416, § 1; A.S.A. 1947, § 83-162; Acts 2003, No. 136, § 1.

### **20-77-107. Program for indigent medical care — Rules and regulations.**

(a)(1) The appropriate division of the Department of Human Services is authorized to establish and maintain an indigent medical care program.

(2) However, eligibility regulations for the ARKids First Program Act, § 20-77-1101 et seq., shall not include an assets or a resource test for children or families of children eighteen (18) years of age or younger.

(b) The Director of the Department of Human Services is further authorized to enter into separate agreements with the University of Arkansas for Medical Sciences and private institutions in order to provide maximum medical care for the indigent persons of this state.

(c) The director may enter into agreements with private or public entities to assist in the enforcement of rules and regulations of an indigent medical program, including:

(1) Utilization review; and

(2) Professional review of providers participating in the program.

(d)(1) The director shall ensure that any entity with whom the department contracts to assist in the enforcement of rules and regulations of an indigent medical program will fulfill its duties in accordance with state and federal law and regulations.



(2) The director may terminate any contractor who excessively burdens the State of Arkansas with the defense of appeals of sanctions or citations of deficiencies that are resolved in favor of the program provider.

(e) Nothing in this subchapter shall be construed to permit the department or any entity with whom it contracts to enforce any rules or regulations that are not lawfully promulgated pursuant to federal or state law, provided that the department and any entity with whom it contracts may rely on official publications of the United States Department of Health and Human Services for the administration of the Medicaid program and other rules, regulations, standards, guidance, or information that apply to the Medicaid program by reference in statute, promulgated regulation, rule, or official federal publication.

(f) The director shall ensure that the professional review of providers, except long-term care facilities and their reviewers, participating in the program comply with the following:

(1) The party conducting any professional reviews of providers participating in the program shall be knowledgeable in the specific areas of law and regulations being enforced;

(2)(A) Every citation or deficiency cited to a provider shall refer by source and number to the authority upon which the citation or deficiency is based.

(B) However, the requirement of subdivision (f)(2)(A) does not limit the department and any entity with whom it contracts in the exercise and application of professional medical judgment in determining when and under what circumstances care is medically necessary;

(3) The professional review process shall include an informal dispute resolution process to allow the provider to challenge the citation or deficiency cited or sanction to a person other than the person making the citation as defined by the director;

(4) The director shall establish a system to ensure standard and consistent application of sanctions and citation or deficiencies among surveyors in different areas of the state; and

(5) The director shall establish a process for program providers to appeal a decision of a reviewer pursuant to the Arkansas Administrative Procedure Act, § 25-15-201 et seq.

**History.** Acts 1989, No. 821, § 7; 1995, No. 710, § 6; 2001, No. 724, § 1; 2003, No. 1182, § 1.

## RESEARCH REFERENCES

**U. Ark. Little Rock L. Rev.** Survey of Assembly, Public Health and Welfare, 24 U. Legislation, 2001 Arkansas General As- Ark. Little Rock L. Rev. 557.

**20-77-111. Data reports.**

(a) The Director of the Department of Human Services shall cause to be prepared a compilation of data on the Arkansas Medicaid Program.

(b)(1) The report shall be issued quarterly and shall include comparisons of expenditures and recipients for the quarter with those of the previous quarters and for the same period the previous year.

(2) It shall include other comparisons in the format as may be requested by the Legislative Council, the House Committee on Public Health, Welfare, and Labor, and the Senate Committee on Public Health, Welfare, and Labor or appropriate subcommittees thereof to which the reports are to be delivered.

(c)(1) The report shall also identify any changes in eligibility requirements, level of benefits, methods or rates of reimbursement, and any program adjustments implemented to achieve savings in any category of the program.

(2) The report shall also identify any increase or decrease in expenditures as a result of any of these changes in the program.

**History.** Acts 1993, No. 1239, § 117; 1997, No. 179, § 32; 2003, No. 1473, § 44; 2013, No. 1132, § 47.

**Amendments.** The 2013 amendment deleted “Interim” twice following “House” and “Senate” in (b)(2).

**20-77-116 — 20-77-118. [Repealed.]**

**Publisher’s Notes.** These sections, concerning the possibility of Medicare waivers to authorize high reimbursements in economically disadvantaged counties, were repealed by Acts 2013, No.

279, § 1. The sections were derived from the following sources:

- 20-77-116. Acts 1999, No. 1595, § 1.
- 20-77-117. Acts 1999, No. 1595, § 2.
- 20-77-118. Acts 1999, No. 1595, § 3.

**20-77-119. Finding — Resource eligibility limit.**

**RESEARCH REFERENCES**

**U. Ark. Little Rock L. Rev.** Survey of Legislation, 2001 Arkansas General Assembly, Public Health and Welfare, 24 U. Ark. Little Rock L. Rev. 557.

**20-77-120. Medicaid waiver for home and community-based care.**

(a) In determining Medicaid eligibility for and providing Medicaid benefits to persons eligible for services through the ElderChoices care program, a home and community-based care waiver pursuant to section 1915(c) of the federal Social Security Act, 42 U.S.C. § 651 et seq., as in effect January 1, 2003, the Department of Human Services, subject to the availability of funds for the purpose and to the extent not prohibited by federal law or regulation, shall use the same division of assets and income allowances for Level 1 and Level 2 ElderChoices applications that are used in determining Medicaid eligibility for and providing Medicaid benefits to persons requiring institutional care.



(b)(1) The department shall apply to the Centers for Medicare & Medicaid Services for an amendment to the ElderChoices Medicaid waiver for home and community-based care waivers if an amendment is necessary to implement the provisions of this section.

(2)(A)(i) The amended waiver shall be funded by savings to the Medicaid program as a result of § 20-77-102(e).

(ii) The department may set aside sufficient funds to pay administrative costs of implementing the program created by § 20-77-102(e) and provide services according to funding availability. If the provisions of § 20-77-102(e) are approved by the Centers for Medicare & Medicaid Services, the department shall project the savings to the Medicaid program that will result from § 20-77-102(e).

(B) The department shall implement the amended waiver using the savings projected in subdivision (b)(2)(A)(ii) of this section to the extent allowed under subdivision (b)(2) of this section.

(c) The department shall promulgate rules to:

(1) Establish a mechanism to track separately from exiting services those clients served and costs incurred by the waiver program established by this section; and

(2) Report the progress of the program at least quarterly to the House Committee on Public Health, Welfare, and Labor and the Senate Committee on Public Health, Welfare, and Labor.

**History.** Acts 2003, No. 1402, § 1; deleted “Interim” twice following “House” 2013, No. 1132, § 48. and “Senate” in (c)(2).

**Amendments.** The 2013 amendment

## **20-77-121. Adverse decisions — Notice — Rights.**

(a) As used in this section:

(1) “Adverse action” means the denial, termination, suspension, or reduction of Medicaid eligibility or covered services;

(2) “Beneficiary” means:

(A) A person who has applied for medical assistance under the state Medicaid program; or

(B) A person who is a recipient of medical assistance under the state Medicaid program; and

(3) “Department” means the Department of Human Services.

(b) If an application or claim for medical assistance is denied, in whole or in part, or is not acted upon with reasonable promptness, the department shall provide written notice:

(1) Of the beneficiary’s right and opportunity for a fair hearing under the Arkansas Administrative Procedure Act, § 25-15-201 et seq.;

(2) Of the method by which the beneficiary may obtain a fair hearing; and that

(3) The beneficiary may:

(A) Represent himself or herself; or

(B) Be represented by:

(i) Legal counsel;

- (ii) A friend; or
- (iii) Any other spokesperson except a corporation.
- (c) A notice required under subsection (b) of this section shall include, but not be limited to:
  - (1) A statement detailing:
    - (A) The type and amount of medical assistance that the beneficiary has requested; and
    - (B) The adverse action that the department has taken or proposes to take; and
  - (2) A statement of the reasons for the adverse action that shall include, but not be limited to:
    - (A) The specific facts regarding the individual beneficiary that support the action; and
    - (B) The sources from which the facts were derived.
  - (d) If the adverse action that the department has taken or proposes to take is based on a determination of medical necessity or other clinical decision, the notice required under subsection (b) of this section shall:
    - (1)(A) Include all of the following:
      - (i) Specification of the medical records upon which the physician or clinician relied in making the determination; and
      - (ii) Specification of any portion of the criteria for medical necessity or coverage that is not met by the beneficiary.
    - (B) Generic rationales or explanations shall not suffice to meet the requirements of subdivision (d)(1)(A) of this section;
  - (2)(A) Include a statement of:
    - (i) The specific regulations that support the adverse action; or
    - (ii) The change in federal or state law, if any, since the application was filed, that requires the adverse action.
  - (B) The information required under subdivision (d)(2)(A) of this section shall include a brief statement of the reasons for the adverse action based on the individual beneficiary's circumstances.
  - (C) The department and others acting on behalf of the department may not cite or rely on policies that are inconsistent with federal or state laws and regulations or that were not properly promulgated; and
- (3) Include an explanation of:
  - (A) The beneficiary's right to request a fair hearing, if available; or
  - (B) In cases of an adverse action based on a change in law:
    - (i) The circumstances under which a fair hearing will be granted; and
    - (ii) An explanation of the circumstances under which medical assistance is provided or continued if a fair hearing is requested.
- (e)(1) If a beneficiary appeals an adverse action under the Arkansas Administrative Procedure Act, § 25-15-201 et seq., the reviewing authority shall consider only those adverse actions that were included in the written notice to the beneficiary as required under subsections (c) and (d) of this section.



(2) All determinations of the medical necessity of any request for medical assistance shall be based on the individual needs of the beneficiary and his or her medical history.

(f) If the department receives an appeal from a beneficiary regarding an adverse action, the department shall provide the beneficiary all records or documents pertaining to the department's decision or the department's contractor's decision to take the adverse action.

(g) If the adverse action is based upon a determination that the requested medical assistance is, or was, not medically necessary, the records and documents required to be provided under this section shall include all relevant material produced by the department or a contractor of the department that contains relevant information concerning the medical necessity determination.

**History.** Acts 2005, No. 2227, § 1.

### **20-77-122. Survey agency for psychiatric residential treatment facilities of children.**

(a) To the extent required by federal law, the Division of Medical Services of the Department of Human Services shall designate a survey agency to conduct restraint and seclusion surveys in psychiatric residential treatment facilities for children as defined in § 9-28-402.

(b) No designation by the division shall act as a waiver of the provisions of § 9-28-407(a)(3) or any other applicable law governing child welfare agencies.

**History.** Acts 2005, No. 2234, § 5.

### **20-77-123. Drugs for asthma and other respiratory diseases.**

(a) As used in this section:

(1) "Drug Review Committee" means physicians and pharmacists who perform unbiased reviews of drugs to determine which drugs should be recommended for inclusion on the Preferred Drug List maintained by the Division of Medical Services of the Department of Human Services;

(2) "Emergency override" means a process developed by the division that permits a pharmacist to obtain immediate permission to dispense an emergency supply of a drug prescribed by the treating physician to treat a medical emergency and for which Medicaid will provide reimbursement;

(3) "Fail-first" means the requirement that a Preferred Drug List drug be utilized prior to the use of a non-Preferred Drug List drug;

(4) "Override" means a process developed by the division that permits a physician to request review of and to seek permission to prescribe a non-Preferred Drug List drug for which Medicaid will provide reimbursement;

(5) “Preferred Drug List” means a list of drugs within a class of drugs for which Medicaid will provide reimbursement without need of a prior authorization; and

(6) “Unbiased review” means a review by physicians and pharmacists, selected, approved, or appointed by the division, of scientific evidence to determine the comparative effectiveness and safety of health care treatments of drugs within a class.

(b) In the event that the division institutes a fail-first practice or policy for drugs for the treatment of asthma or other respiratory diseases, the division shall provide a process to request an override.

(c) In cases of medical emergencies resulting from asthma or other acute respiratory diseases, the dispensing pharmacist shall seek an emergency override before dispensing the emergency supply of drug or drugs to treat the medical emergency condition.

**History.** Acts 2005, No. 2251, § 1.

## **20-77-124. Medicaid waiver for autism.**

(a) As used in this section:

(1)(A) “Intensive early intervention individualized therapy services” means intensive early intervention individualized therapy for a child with a pervasive developmental disorder, including without limitation:

(i) Behavioral therapies such as applied behavioral analysis and pivotal response training under the supervision of a behavior analyst who is board certified by the Behavior Analyst Certification Board;

(ii) Intensive speech therapy provided by a licensed speech therapist; and

(iii) Intensive occupational therapy provided by a licensed occupational therapist.

(B) Except as provided in subdivision (a)(1)(C) of this section, “intensive early intervention individualized therapy services” does not include coverage for services to treat developmental disorders of language, early onset psychosis, dementia, obsessive compulsive disorder, schizoid personality disorder, avoidant personality disorder, or reactive attachment disorder.

(C) If a child with a pervasive developmental disorder is diagnosed to have one (1) or more of the conditions listed in subdivision (a)(1)(B) of this section, intensive early intervention individualized therapy services includes coverage only for therapy necessary to treat the pervasive developmental disorder; and

(2) “Pervasive developmental disorders”, commonly known as autism spectrum disorders, means a neurobiological condition characterized by severe deficits and pervasive impairment in multiple areas of development diagnosed by a team evaluation including at least a licensed physician, a licensed psychologist, and a licensed speech pathologist for an individual with a developmental disability as defined in § 20-48-101, including without limitation:



- (A) Asperger's disorder;
- (B) Autism;
- (C) Pervasive developmental disorder, not otherwise specified;
- (D) Rett's disorder; and
- (E) Childhood disintegrative disorder.

(b)(1) The Department of Human Services shall seek a Medicaid waiver from the Centers for Medicare & Medicaid Services to provide intensive early intervention individualized therapy services to any child who has been diagnosed with a pervasive developmental disorder.

(2)(A) The waiver shall be for children three (3) years of age through ten (10) years of age.

(B) No child shall participate in the Medicaid waiver under this section for more than three (3) years.

(C) The Medicaid waiver under this section shall not pay more than fifty thousand dollars (\$50,000) annually per child.

(3) The waiver shall seek to develop skills of children in the areas of cognition, behavior, communication, and social interaction.

(c) The department shall apply for the Medicaid waiver under this section only as funding becomes available for that purpose.

**History.** Acts 2007, No. 1198, § 1.

## **20-77-125. Contingency fee audits prohibited.**

(a) As used in this section:

(1) "Healthcare provider" means a person enrolled to provide health or medical care services or goods authorized under Medicaid;

(2) "Medicaid" means the medical assistance program provided in this state under Title XIX of the Social Security Act of 1965, 42 U.S.C. § 1396 et seq., including components of the program;

(3) "Medicaid integrity audit contract" means a contract required under federal law between the Department of Human Services and a Medicaid integrity audit program contractor to:

(A) Review the actions of healthcare providers furnishing services or goods for which payment may be made under the Medicaid program to determine whether fraud, waste, or abuse has occurred or is likely to occur, or whether fraud, waste, or abuse has the potential for resulting in an expenditure of Medicaid funds that is not intended under the Medicaid program;

(B) Audit Medicaid claims to ensure proper payments were made; or

(C) Identify overpayments made to individuals or entities receiving Medicaid funds; and

(4) "Person" means any individual, company, firm, organization, association, corporation, or other legal entity.

(b) The Division of Medical Services of the Department of Human Services shall not enter into a Medicaid integrity audit contract that authorizes all or part of an auditor's compensation to be based, directly

or indirectly, on the amount of overpayments identified or collected by the auditor.

(c)(1) Within forty-five (45) days after April 11, 2013, the division shall seek a waiver from the Centers for Medicare & Medicaid Services of the requirement that recovery audit contractors, as identified in 42 U.S.C. § 1396a(a)(42)(B), be paid on a contingent fee basis by submitting an amendment to the Medicaid state plan to implement the requirements of this section.

(2)(A) Except as under subdivision (c)(2)(B) of this section, this section does not apply to:

(i) A contract with a Medicaid integrity audit contractor entered into before the state plan amendment is approved by the Centers for Medicare & Medicaid Services; or

(ii) An existing contingent fee contract entered into before July 1, 2013.

(B) An existing contingent fee contract shall not be renewed from and after July 1, 2013, April 11, 2013, or the date a waiver from the Centers for Medicare & Medicaid Services becomes effective, whichever is later.

**History.** Acts 2013, No. 1109, § 1.

#### **20-77-126. Relation to Arkansas Pharmacy Audit Bill of Rights.**

(a) From and after the date that a state plan amendment submitted under § 20-77-125 is approved by the Centers for Medicare & Medicaid Services, § 20-77-125 shall supersede and replace § 17-92-1201(f) with regard to Medicaid integrity audits of pharmacies and pharmacists, but all other subsections of § 17-92-1201 shall continue in full force and effect with regard to Medicaid integrity audits.

(b) Section 17-92-1201 is not affected by § 20-77-125 with regard to audits conducted by or on behalf of a person or entity other than Medicaid integrity audits under subsection (a) of this section.

**History.** Acts 2013, No. 1109, § 1.

#### **20-77-127. Eligibility for long-term care.**

(a) The eligibility determination regarding every applicant for long-term care nursing facility placement shall be made according to the criteria exactly as set forth in:

(1) The Office of Long-Term Care Procedures for Determination of Medical Need for Nursing Home Services, as it existed on January 1, 2013; and

(2) The Medical Services Policy Manual of the Division of County Operations of the Department of Human Services, as it existed on January 1, 2013.

(b) The eligibility determination criteria established under subsection (a) of this section and any part of subsection (a) of this section shall not be modified, altered, amended, or changed before June 30, 2014.



**History.** Acts 2013, No. 1217, § 1.

**20-77-128. In-home caregiver drug tests and criminal background checks.**

(a) As used in this section, “caregiver” means an individual who has responsibility for the protection, in-home care, or custody of a Medicaid enrollee as a result of assuming the responsibility by contract.

(b)(1) A caregiver shall submit to a drug screen that tests for the use of illegal drugs through a program established by the Department of Human Services.

(2) A drug screen under this section shall be administered to:

(A) A caregiver on or after September 1, 2013; and

(B)(i) A random sampling of caregivers on or after September 1, 2013.

(ii) The random sampling shall be designed to ensure that each caregiver is tested for illegal drug use under this section at least one (1) time every five (5) years.

(iii) A caregiver who has been tested through a home health agency within the previous five (5) years for the use of illegal drugs may satisfy the testing requirement under this subsection by providing verification of the home health agency test.

(3)(A) A caregiver who refuses to submit to a drug screen required under this section or who tests positive for the use of illegal drugs in a drug screen required under this section shall be ineligible for employment paid with Medicaid funds for six (6) months after the date of the refusal or the date of the positive test result.

(B)(i) After the six-month period under subdivision (b)(3)(A) of this section, the caregiver may volunteer to undergo a new test for the use of illegal drugs under this section.

(ii) If the caregiver tests positive for the use of illegal drugs in a voluntary drug screen under this section, the caregiver shall be ineligible for future employment paid with Medicaid funds.

(c)(1) The Department of Human Services shall:

(A) Require a state criminal background check of a caregiver and of an applicant to become a caregiver by the Identification Bureau of the Department of Arkansas State Police that conforms to the applicable standards; and

(B) For a person who has not resided continuously in Arkansas during the previous five (5) years, require a federal criminal background check of a caregiver and of an applicant to become a caregiver by the Federal Bureau of Investigation that conforms to the applicable standards and includes the taking of fingerprints.

(2) A caregiver or an applicant to become a caregiver shall pay for the payment of any fee associated with the criminal records check under this subsection.

(3) Before a criminal background check is performed, a caregiver or an applicant to become a caregiver shall sign a release authorizing the background check.

(4) Upon completion of the criminal background check, the Identification Bureau of the Department of Arkansas State Police shall forward to the Department of Human Services information obtained concerning the caregiver or applicant to become a caregiver that indicates that the caregiver or applicant to become a caregiver has pleaded guilty or nolo contendere to or has been found guilty of a felony or crime involving moral turpitude or dishonesty.

(5) The results of the background check shall be used by the Department of Human Services to determine the suitability of:

(A) An applicant to become a caregiver paid with Medicaid funds;  
or

(B) A caregiver for continued employment paid with Medicaid funds.

(6) A caregiver or applicant to become a caregiver who has pleaded guilty or nolo contendere to or has been found guilty of a felony or crime involving moral turpitude or dishonesty shall not be employed to provide services paid with Medicaid funds.

(7) The criminal background information of a caregiver or applicant to become a caregiver is confidential.

(d)(1) The Department of Human Services shall adopt rules to implement this section.

(2) If necessary, the Department of Human Services shall seek a waiver from the Centers for Medicare & Medicaid Services for approval of the rules adopted under this section.

**History.** Acts 2013, No. 1336, § 1.

## **20-77-129. Ambulatory surgery centers — Medicaid reimbursement.**

(a) As used in this section:

(1) “Ambulatory surgery center” means a distinct entity certified by Medicare as an Ambulatory Surgical Center that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization;

(2) “Ambulatory Surgery Center Medicaid Procedure Code” means appropriate procedures that do not appear on the Medicare hospital inpatient-only list or Medicaid hospital inpatient-only list and that are medically necessary and not solely for cosmetic treatment or surgery;

(3) “Ambulatory Surgery Center Medicaid reimbursement formula for appropriate implantable devices” means appropriate implantable devices used during appropriate procedures that are reimbursed at a pass-through cost if the combined cost of the appropriate implantable devices is greater than fifty percent (50%) of the reimbursement for the Ambulatory Surgery Center Medicaid Procedure Code;

(4) “Ambulatory Surgical Center Medicaid reimbursement rate for appropriate procedures” means eighty percent (80%) of hospital outpatient procedure department Medicare reimbursement for Ambulatory Surgical Center Medicaid Procedure Codes;



(5) "Appropriate implantable device" means a device used during an appropriate procedure;

(6) "Appropriate procedure" means a procedure that is not on the Medicaid hospital inpatient-only list or Medicare hospital inpatient-only list;

(7) "Healthcare Financing Administration Common Procedure Coding System" means the coding system under the Centers for Medicare & Medicaid Services;

(8) "Hospital inpatient-only list" means procedures that should be performed on an inpatient basis for the Medicare population due to one (1) or more of the following reasons:

(A) The nature of the procedure;

(B) The need for at least twenty-four (24) hours of postoperative care; and

(C) The underlying physical condition of those patients most often having the particular procedure;

(9) "Hospital outpatient procedure department" means a hospital-based ambulatory surgery center that bills in accordance with the Outpatient Hospital Services Medicaid Provider Guide; and

(10) "Relative Value Unit" means a service unit value measured in relation to the values of other services and involving a Current Procedural Terminology code that, when multiplied by the conversion factor and a geographical adjustment, creates the compensation level for a particular service.

(b) The purpose of this act is to decrease the cost of Medicaid while increasing access to care to Arkansas's Medicaid population.

(c)(1) An appropriate procedure may be performed at an ambulatory surgery center or a hospital outpatient procedure department.

(2) If an appropriate procedure is performed at an ambulatory surgery center or at a hospital outpatient procedure department, the appropriate procedure and any appropriate implantable devices shall be billed using the Ambulatory Surgery Center Medicaid Procedure Codes and reimbursed pursuant to the Ambulatory Surgery Center Medicaid reimbursement formula for appropriate procedures and the Ambulatory Surgical Center Medicaid reimbursement formula for appropriate implantable devices.

(d) If an Ambulatory Surgery Center Medicaid Procedure Code is not on the Medicaid hospital inpatient-only list but is on the Medicare hospital inpatient-only list, the Ambulatory Surgery Center Medicaid reimbursement formula for appropriate procedures shall be eighty percent (80%) of the Medicare hospital outpatient procedure department reimbursement for a comparable procedure, based on a Relative Value Unit that is not on the Medicare hospital inpatient-only list.

**History.** Acts 2013, No. 1352, § 1.

**20-77-130. Medicaid provider tax returns.**

(a) As used in this section, “Affected Medicaid Entity” means an individual or entity that:

(1) Provides and is directly reimbursed by Medicaid for services in the Arkansas Medicaid Program;

(2) Is required to submit an annual financial audit to the Department of Human Services; and

(3) Is required to file a state income tax return, state withholding tax return, pass-through entity withholding tax return, or a composite pass-through entity tax return or pay any tax due for the previous calendar year.

(b)(1) On or before December 1 of each year, the Department of Human Services shall provide the Department of Finance and Administration with a list of the tax identification number of each person and entity enrolled to furnish Medicaid services as an Affected Medicaid Entity.

(2) The Department of Finance and Administration shall:

(A) Verify whether each person and entity enrolled to furnish Medicaid services identified to it under subdivision (b)(1) of this section filed and paid any state income tax liability owed for the tax year for which the return was due; and

(B) Notify the Department of Human Services if any Affected Medicaid Entity failed to file any state income tax return, state withholding tax return, pass-through entity withholding tax return, or a composite pass-through entity tax return or pay any tax due for the previous calendar year.

(3) Upon receiving notice from the Department of Finance and Administration under subdivision (b)(2) of this section, the Department of Human Services shall notify the Affected Medicaid Entity that the Department of Human Services will terminate the Affected Medicaid Entity’s enrollment in the Medicaid program unless the Affected Medicaid Entity shows good cause why the Affected Medicaid Entity’s Medicaid enrollment should continue.

(c) The Department of Human Services and the Department of Finance and Administration may adopt rules as needed to implement this section.

**History.** Acts 2013, No. 1436, § 1.

**SUBCHAPTER 3 — THIRD-PARTY LIABILITY**

SECTION.

20-77-301. Action by Department of Human Services.

20-77-303. Action by division and recipient.

20-77-304. Notice of action or claim — Intervention or consolidation.

SECTION.

20-77-305. Notice to Department of Human Services of award or settlement by recipient required.

20-77-306. Liability of third parties to Department of Human Services.



## SECTION.

20-77-314. Definitions.

20-77-315. Distribution of proceeds from  
a third-party settlement,judgment, or award or  
from other third-party  
payment.**20-77-301. Action by Department of Human Services.**

(a)(1) When medical assistance benefits are provided or will be provided to a medical assistance recipient because of injury, disease, disability, or death for which a third party is or may be liable, the appropriate division of the Department of Human Services may recover from the person the cost of benefits so provided.

(2) To enforce the right under subdivision (a)(1) of this section, the department may institute and prosecute legal proceedings against the third person who may be liable.

(b)(1) An action taken on behalf of the division under this section or any judgment rendered in the action shall not be a bar to any action upon the claim or cause of action of the recipient, his or her guardian, personal representative, estate, or survivors against the third party who is or may be liable for the injury.

(2) An action under this section does not deny to the recipient the recovery for that portion of any damages not covered hereunder.

(c)(1) The department may recover from a third party the cost of benefits for medical care provided to indigent persons from third persons, another program administered by the department, or a program administered through another department or agency of state government.

(2) The department shall remit to other departments or agencies of state government any amounts recovered, less its pro rata share and costs of collection, for care provided by them.

(d)(1) In actions in tort hereunder, no contributory or comparative fault of a recipient shall be attributed to the state, nor shall any restitution awarded to the state be denied or reduced by any amount or percentage of fault attributed to a recipient.

(2) Notwithstanding subdivision (d)(1) of this section, if the recipient used a device, machine, or product after being warned, either verbally or in writing, that the use, misuse, or improper operation of the device, machine, or product was dangerous, risky, or could result in injury or harm to the recipient, then the statutory or common law defenses of contributory or comparative fault or negligence that could be asserted by the defendant against the recipient may also be asserted by the defendant in any action by the department or other agency of state government, and if the defenses are supported by the evidence, then recovery may be denied or reduced in the same manner as if the recipient were the plaintiff.

**History.** Acts 1979, No. 419, § 1; A.S.A. 1947, § 83-171; Acts 1992 (1st Ex. Sess.), No. 54, § 1; 1993, No. 1225, § 1; 2011, No. 625, § 1.

**Amendments.** The 2011 amendment substituted "disease, disability, or death for which a third party is or may be liable" for "disease, or disability, for which an-

other person is liable" in (a)(1); in (a)(2), added "To enforce the right under subdivision (a)(1) of this section" at the beginning and deleted "to enforce the right" preceding "institute"; substituted "party who is or may be liable" for "person who may be liable" in (b)(1); subdivided part of

(c); and, in (c)(1), substituted "may" for "shall likewise have the authority to," inserted "from a third party," and deleted "whether or not the case was provided pursuant to the Arkansas Health Care Access Program" following "third persons."

## RESEARCH REFERENCES

**Ark. L. Rev. Comment, Is the Made-Whole Requirement More than We Bargained For?: From Franklin to Tallant--a Call to Reexamine the Made-Whole Doctrine in Arkansas**, 60 Ark. L. Rev. 295.

**An Accident Waiting to Happen: Arkansas Department of Health and Human Services v. Ahlborn Exposes Inequities in Medical Benefits Legislation**, 60 Ark. L. Rev. 533.

## CASE NOTES

**Cited:** Ark. HHS v. Ahlborn, 547 U.S. 268, 126 S. Ct. 1752, 164 L. Ed. 2d 459 (2006).

### 20-77-302. Action by recipient alone — Reimbursement of division.

## CASE NOTES

#### In General.

State laws regarding assignment and recovery of Medicaid payments were preempted to the extent they required the recipient to assign her rights to recover third-party liability payments for matters other than the cost of her medical care and

services. Ahlborn v. Ark. Dep't of Human Servs., 397 F.3d 620 (8th Cir. 2005), *aff'd*, Ark. HHS v. Ahlborn, 547 U.S. 268, 126 S. Ct. 1752, 164 L. Ed. 2d 459 (2006).

**Cited:** Ark. HHS v. Ahlborn, 547 U.S. 268, 126 S. Ct. 1752, 164 L. Ed. 2d 459 (2006).

### 20-77-303. Action by division and recipient.

(a) If an action is prosecuted both by the medical assistance recipient and the division against a third party who is or may be liable for injury, disease, disability, or death of the medical assistance recipient, then in the event of judgment or award in a suit or claim against the third party, the court shall first order paid from any judgment or award the reasonable litigation expenses incurred in prosecution of the action or claim, together with reasonable attorney's fees based solely on the services rendered for the benefit of the recipient.

(b) After payment of expenses and attorney's fees, the court shall order that the division receive an amount sufficient to reimburse the division the full amount of benefits paid on behalf of the recipient under the medical assistance program.

(c) The remainder shall be awarded to the medical assistance recipient.



**History.** Acts 1979, No. 419, § 3; A.S.A. 1947, § 83-171.2; Acts 2011, No. 625, § 2. substituted “party” for “person,” inserted “or may be,” and substituted “disability, or death” for “or disability.”

**Amendments.** The 2011 amendment, in (a), inserted “medical assistance” twice,

### **20-77-304. Notice of action or claim — Intervention or consolidation.**

(a)(1) If either the medical assistance recipient or the appropriate division brings an action or claim against a third party, the recipient or Department of Human Services shall give to the other party written notice of the action or claim by personal service or registered mail within thirty (30) days of filing the action.

(2) This notice shall contain the names of the third party and the court in which the action is brought.

(3) Proof of the notice shall be filed in the action.

(4) If an action or claim is brought by either the department or the medical assistance recipient, the other may become a party to the action, at any time before trial on the facts, or shall consolidate his or her action or claim with the other if brought independently, at any time before trial on the facts.

(b)(1) If the recipient, his or her guardian, personal representative, estate, or survivors bring an action against the third party who may be liable for injury, disease, or disability, then notice of institution of the legal proceedings and notice of settlement shall be given the Director of the Department of Human Services.

(2) All notices shall be given by the attorney retained to assert the medical assistance recipient’s claim or by the medical assistance recipient, his or her guardian, personal representative, estate, or survivors if an attorney is not retained.

**History.** Acts 1979, No. 419, § 4; A.S.A. 1947, § 83-171.3; Acts 1987, No. 463, § 2; 2011, No. 625, § 3. (a)(1); in (a)(4), inserted “the medical assistance” and inserted “at any time before trial on the facts” at the end; subdivided part of (b); and, in (b)(2), inserted “medical assistance” twice.

**Amendments.** The 2011 amendment substituted “party” for “person” in (a)(1), (a)(2), and (b)(1); inserted “appropriate” in

### **20-77-305. Notice to Department of Human Services of award or settlement by recipient required.**

(a) A judgment, an award, or a settlement in any action or claim by a medical assistance recipient to recover damages for injuries, disease, disability, or death in which the Department of Human Services has an interest, shall not be satisfied without first giving the department notice and a reasonable opportunity to establish its interest.

(b) If a recipient, his or her guardian, attorney, or personal representative disposes of the funds that are to be held for the benefit of the department under this section without the written approval of the department, that person shall be liable to the department for any

amount that, as a result of the disposition of the funds, is not recoverable by the department.

(c) In addition to the amount of the department's claim, a recipient, his or her guardian, attorney, or personal representative who knowingly fails to obtain written approval from the department before disposing of funds under this section is liable to the department for:

- (1) A penalty equal to ten percent (10%) of the amount of the department's claim; and
- (2) Reasonable costs and attorney's fees.

**History.** Acts 1979, No. 419, § 5; 1981, No. 500, § 3; A.S.A. 1947, § 83-171.4; Acts 1987, No. 463, § 3; 2009, No. 710, § 1; 2011, No. 625, § 4.

**Amendments.** The 2009 amendment added (c).

The 2011 amendment substituted "disability, or death" for "or disability" in (a).

### **20-77-306. Liability of third parties to Department of Human Services.**

(a) As used in this section:

(1) "Health insurer" means a commercial insurance company offering health or casualty insurance to individuals or groups including without limitation experience-rated insurance contracts and indemnity contracts that offer the following:

(A) Automobile insurance, including casualty, medical payment, uninsured motorist bodily injury coverage, and underinsured benefits except benefits payable for or limited under the terms of the policy to property damage or wrongful death;

(B) A group health plan as defined in § 607(1) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001 et seq., as it existed on January 1, 2007;

(C) A health care plan as defined in § 23-76-102 or similar laws of another state;

(D) A health maintenance organization;

(E) A liability insurance plan;

(F) A hospital and medical service corporation as defined in § 23-75-101;

(G) A managed care organization;

(H) A company that offers or administers health or casualty insurance to individuals or groups;

(I) A profit or nonprofit prepaid plan offering either medical services or full or partial payment for services that are reimbursed by Medicaid;

(J) An organization administering health or casualty insurance plans, including self-insured and self-funded plans;

(K) Other parties that are by statute, contract, or agreement, legally responsible for payment of a health care item or service;

(L) A pharmacy benefits manager; and

(M) Workers' compensation;

(2) "Medicaid" means the medical assistance program established under § 20-77-101 et seq.; and



(3) "Third party" means an individual, an entity, or a program that is or may be liable to pay all or part of the expenditures for Medicaid services furnished by Medicaid.

(b) A third party or health insurer that is legally liable for any medical cost of an injury, disease, disability, or condition requiring medical treatment for which Medicaid has paid, or has assumed liability to pay, shall be liable to reimburse Medicaid the lesser of:

(1) The difference between:

(A) The amount previously paid in good faith by a third party or health insurer to a recipient or health care provider for the medical cost of an injury, a disease, or a disability; and

(B) The full amount of the liability of the third party or health insurer; or

(2) The full amount paid by Medicaid for the medical cost of an injury, a disease, or a disability.

(c) Upon request of the Department of Human Services, a health insurer doing business in this state shall provide the department with eligibility and coverage information that will enable the department to determine:

(1) Which Medicaid recipients may be or may have been covered by the third party or health insurer;

(2) The period of the coverage;

(3) The coverage; and

(4) The name, address, and identifying number of the plan.

(d) A health insurer shall:

(1) Accept Medicaid's right of recovery and the assignment to Medicaid of the right of a Medicaid recipient or other entity for payment from the health insurer or a third party for an item or a service for which Medicaid has made payment;

(2) Subject to the time limits imposed under subdivision (d)(3) of this section and subsection (f) of this section, process and, if appropriate, pay Medicaid reimbursement claims to the same extent that the plan would have been liable had it been properly billed at the point of sale; and

(3) Agree not to deny claims submitted by the department based on:

(A) A failure to present proper documentation of coverage at the point of sale; or

(B) The date of submission of the claim if the claim is submitted within three (3) years from the date on which the claimed item or service was furnished.

(e) The assignment to Medicaid of the right of a Medicaid recipient or other entity for payment from the third party or health insurer for an item or a service for which Medicaid has made payment occurs at the time the recipient requests an item or a service.

(f)(1) A health insurer shall respond to any inquiry by the department regarding claims submitted within three (3) years after the date on which the item or service was furnished.

(2) The department shall begin an action to enforce Medicaid’s rights with respect to a claim within six (6) years of the department’s submission of the claim.

(g) Nothing in this subchapter requires a health insurer to reimburse Medicaid for items or services that Medicaid does not or did not cover for the recipient.

(h)(1) The department shall adopt rules necessary to implement this subchapter.

(2) The rules shall:

(A) Conform to the Arkansas Administrative Procedure Act, § 25-15-201 et seq.; and

(B) Include provisions for contractual agreements between the department and health insurers specifying the procedures for data exchanges made under this subchapter.

**History.** Acts 1981, No. 500, § 4; A.S.A. 1947, § 83-171.5; Acts 1987, No. 463, § 4; 2007, No. 537, § 1; 2009, No. 952, § 16.

**Amendments.** The 2007 amendment rewrote the section.

The 2009 amendment transferred “a failure to” from the end of the introductory language of (d)(3) to the beginning of (d)(3)(A), and made related changes.

**20-77-307. Assignment to Department of Human Services of rights of recovery.**

**RESEARCH REFERENCES**

**Ark. L. Rev.** An Accident Waiting to Happen: Arkansas Department of Health and Human Services v. Ahlborn Exposes

Inequities in Medical Benefits Legislation, 60 Ark. L. Rev. 533.

**CASE NOTES**

**ANALYSIS**

In General.  
Third Party Recovery.

**In General.**

Although recipients of Medicaid benefits are required to assign rights to third-party liability to the Arkansas Department of Health and Human Services (ADHHS), such assignment, and the lien of the ADHHS, only extends to third-party liability for medical expenses; any third-party liability for other damages is not assigned or lienable to reimburse the ADHHS for the full amount of benefits paid. Ark. HHS v. Ahlborn, 547 U.S. 268, 126 S. Ct. 1752, 164 L. Ed. 2d 459 (2006).

Although the Arkansas collateral source rule applied to bar the United States from presenting evidence showing that the

amount paid for medical services was less than the billed amounts because the decedent at issue was covered by Medicaid, the application of the rule would not bar recovery of the Medicaid payments, should plaintiffs prevail in their 28 U.S.C.S. § 2674 of the Federal Tort Claims Act suit. An action could later be brought under this section to recover the Medicaid payments by executing a lien on plaintiffs’ recovery. McMullin v. United States, 515 F. Supp. 2d 904 (E.D. Ark. 2007).

**Third Party Recovery.**

State laws regarding assignment and recovery of Medicaid payments were preempted to the extent they required the recipient to assign her rights to recover third-party liability payments for matters other than the cost of her medical care and services. Ahlborn v. Ark. Dep’t of Human Servs., 397 F.3d 620 (8th Cir. 2005), aff’d,



Ark. HHS v. Ahlborn, 547 U.S. 268, 126 S. Ct. 1752, 164 L. Ed. 2d 459 (2006).

Where a recipient of Medicaid benefits settled with alleged tortfeasors for medical expenses and other damages related to future care, permanent injury, pain and suffering, and lost earnings, the recipient's assignment of third-party liability to the Arkansas Department of Health and

Human Services (ADHHS), and the lien of the ADHHS, extended only to the portion of the settlement attributable to the recipient's medical expenses and did not extend to the portion of the settlement attributable to other damages. Ark. HHS v. Ahlborn, 547 U.S. 268, 126 S. Ct. 1752, 164 L. Ed. 2d 459 (2006).

## **20-77-314. Definitions.**

As used in this subchapter:

(1) "Action" or "Claim" means a complaint, demand letter, or any other notification given to a third party by the Department of Human Services, the medical assistance recipient, the recipient's attorney, or any person acting on behalf of the recipient that the department or the medical assistance recipient requests payment from a third party for damages to the medical assistance recipient for injury, disease, disability, or death for which a third party is or may be liable;

(2)(A) "Medical assistance recipient" means any person, including a minor, on whose behalf the department has paid medical assistance payments due to injury, disease, or disability.

(B) "Medical assistance recipient" includes a party acting on behalf of the medical assistance recipient, such as a parent, guardian, conservator, other personal representative, estate, or survivor; and

(3) "Third party" means an individual, entity, or a program that is or may be liable to pay all or part of the expenditures for medical assistance payments made by the department.

**History.** Acts 2011, No. 630, § 1.

## **20-77-315. Distribution of proceeds from a third-party settlement, judgment, or award or from other third-party payment.**

(a) The Department of Human Services is entitled to reimbursement for past medical assistance payments from that portion of a third-party settlement, judgment, or award or from any other third-party payment that compensates for the medical expenses.

(b) The department is entitled to receive the full amount of its medical assistance claim under this subchapter unless the portion of the third-party settlement, judgment, or award or other third-party payment that compensates for the medical expenses is less than the full amount of the department's medical assistance claim.

(c) The department's claim for medical assistance payments under this subchapter has priority over any claim by a medical care provider.

(d) The department's rights under this subchapter are not extinguished by any right possessed, asserted or not asserted, by a medical assistance recipient or other person.

**History.** Acts 2011, No. 746, § 1; 2013, No. 1132, § 49.

**Amendments.** The 2013 amendment

inserted “or” following “settlement, judgment” in the section heading and in (a) and (b).

## SUBCHAPTER 4 — PRESCRIPTION DRUGS

**A.C.R.C. Notes.** Acts 2013, No. 1496, § 14, provided: “MEDICAL SERVICES — GENERAL MEDICAID RATE METHODOLOGY PROVISIONS.

“(a) Rates established by the Division of Medical Services for the services or programs covered by this Act shall be calculated by the methodologies approved by the Centers for Medicare and Medicaid Services (CMS). The Division of Medical Services shall have the authority to reduce or increase rates based on the approved methodology. Further, the Division of Medical Services shall have the authority to increase or decrease rates for good cause including, but not limited to:

“(1) Identification of provider(s) who can render needed services of equal quality at rates less than traditionally charged and who meet the applicable federal and state laws, rules and regulations pertaining to the provision of a particular service;

“(2) Identification that a provider or group of providers has consistently charged rates to the Arkansas Medicaid Program greater than to other purchasers of medical services of similar size;

“(3) The Division determines that there has been significant changes in the technology or process by which services are provided by a provider or group of providers which has affected the costs of providing services, or;

“(4) A severe economic downturn in the Arkansas economy which has affected the overall state budget of the Division of Medical Services.

“The Division of Medical Services shall make available to requesting providers, the CMS’s inflationary forecasts (CMS Market Basket Index). Rates established with cost of living increases based on the CMS Market Basket Index or other indi-

ces will be adjusted annually except when the state budget does not provide sufficient appropriation and funding to affect the change or portion thereof.

“(b) Any rate methodology changes proposed by the Division of Medical Services both of a general and specific nature, shall be subject to prior approval by the Legislative Council or Joint Budget Committee.

“Determining the maximum number of employees and the maximum amount of appropriation and general revenue funding for a state agency each fiscal year is the prerogative of the General Assembly. This is usually accomplished by delineating such maximums in the appropriation act(s) for a state agency and the general revenue allocations authorized for each fund and fund account by amendment to the Revenue Stabilization law. Further, the General Assembly has determined that the Department of Human Services — Division of Medical Services may operate more efficiently if some flexibility is provided to the Department of Human Services — Division of Medical Services authorizing broad powers under this section. Therefore, it is both necessary and appropriate that the General Assembly maintain oversight by requiring prior approval of the Legislative Council or Joint Budget Committee as provided by this section. The requirement of approval by the Legislative Council or Joint Budget Committee is not a severable part of this section. If the requirement of approval by the Legislative Council or Joint Budget Committee is ruled unconstitutional by a court of competent jurisdiction, this entire section is void.

“The provisions of this section shall be in effect only from July 1, 2013 through June 30, 2014.”

## 20-77-403. Fees paid to participating pharmacists.

**A.C.R.C. Notes.** Acts 2013, No. 1496, § 13, provided: “MEDICAL SERVICES —

PHARMACEUTICAL DISPENSING FEE SURVEY. No more than two years prior to



making any changes to the current pharmaceutical dispensing fee, the State shall conduct an independent survey utilizing generally accepted accounting principles, to determine the cost of dispensing a prescription by pharmacists in Arkansas. Only factors relative to the cost of dispensing shall be surveyed. These factors shall not include actual acquisition costs or average profit or any combination of actual acquisition costs or average profit. The survey results shall be the basis for

establishing the dispensing fee paid to participating pharmacies in the Medicaid prescription drug program in accordance with Federal requirements. The dispensing fee shall be no lower than the cost of dispensing as determined by the survey. Nothing in this section shall be construed to prohibit the State from increasing the dispensing fee at any time.

"The provisions of this section shall be in effect only from July 1, 2013 through June 30, 2014."

## SUBCHAPTER 5 — EYE CARE

### SECTION.

20-77-504. Penalty.

20-77-506. Right of freedom of choice.

### 20-77-501. Definition.

**Publisher's Notes.** Sections 17-89-201 et seq. and 17-93-201 et seq., referred to in this section, have been renumbered as

§ 17-90-101 et seq. and § 17-95-201 et seq., respectively.

### 20-77-502. Applicability.

**Publisher's Notes.** Sections 17-89-201 et seq. and 17-93-201 et seq., referred to in this section, have been renumbered as

§ 17-90-101 et seq. and § 17-95-201 et seq., respectively.

### 20-77-503. Practice of optometry not affected.

**Publisher's Notes.** Section 17-89-201 et seq., referred to in this section, has been renumbered as § 17-90-101 et seq.

### 20-77-504. Penalty.

(a) Any person violating this subchapter shall be guilty of a violation and upon conviction shall be fined in any sum not less than ten dollars (\$10.00) nor more than twenty-five dollars (\$25.00).

(b) Each violation shall constitute a separate offense and shall be punishable as such.

**History.** Acts 1973, No. 10, § 5; A.S.A. 1947, § 83-1005; Acts 2005, No. 1994, § 139.

### 20-77-506. Right of freedom of choice.

(a) Every person eligible for an eye examination the payment for which shall or may be made out of public money is guaranteed his or her freedom of choice between persons licensed under the laws governing

the practice of optometry, § 17-90-101 et seq., and persons licensed under the Arkansas Medical Practices Act, § 17-95-201 et seq., § 17-95-301 et seq., and § 17-95-401 et seq.

(b) Every person eligible for an ear examination the payment for which shall or may be made out of public money is guaranteed his or her freedom of choice between persons licensed under the Licensure Act of Speech-Language Pathologists and Audiologists, § 17-100-101 et seq., or persons licensed under the Arkansas Medical Practices Act, § 17-95-201 et seq., § 17-95-301 et seq., and § 17-95-401 et seq.

**History.** Acts 1973, No. 10, § 1; A.S.A. 1947, § 83-1001; Acts 2003, No. 1455, § 1.

## SUBCHAPTER 8 — HOME INTRAVENOUS DRUG THERAPY SERVICES

### SECTION.

#### 20-77-801. Definitions.

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**Effective Dates.** Acts 2003, No. 1473, § 74: July 1, 2003. Emergency clause provided: "It is found and determined by the General Assembly of the State of Arkansas that this act includes technical corrects to Act 923 of 2003 which establishes the classification and compensation levels of state employees covered by the provisions of the Uniform Classification and

Compensation Act; that Act 923 of 2003 will become effective on July 1, 2003; and that to avoid confusion this act must also [sic] effective on July 1, 2003. Therefore, an emergency is declared to exist and this act being necessary for the preservation of the public peace, health, and safety shall become effective on July 1, 2003."

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#### 20-77-801. Definitions.

As used in this subchapter:

(1)(A) "Home intravenous drug therapy services" means the items and services described in subdivision (1)(B) of this section furnished to an individual who is under the care of a physician in a place of residence used as the individual's home, by a qualified home intravenous drug therapy provider, and under a plan established and periodically reviewed by a physician.

(B) "Home intravenous drug therapy services" includes pharmacy and related services, including medical supplies, intravenous fluids, and equipment used in administering intravenous fluids as are necessary to conduct safely and effectively an intravenous-administered drug regimen;

(2) "Qualified pharmacy home intravenous drug therapy provider" means any entity that the Arkansas State Board of Pharmacy determines meets the following requirements:

(A) Is capable of providing home intravenous drug therapy services;



(B) Makes services available, as needed, seven (7) days a week on a twenty-four-hour basis;

(C) Adheres to the appropriate written protocols and policies with respect to the provision of items and services;

(D) Maintains clinical records on all patients;

(E) Coordinates all services with the patient’s physician;

(F) Maintains patient records as to frequency of nursing visits, certificate of medical necessity from the attending physician, progress reports on the patient, and a patient care plan;

(G) Conducts a quality assessment and assurance program, including drug regimen review and coordination of patient care;

(H) Provides sterile compounding of intravenous drugs in an atmosphere which contains less than one thousand (1,000) particles 0.5 microns or larger in diameter per cubic foot of air and positive air flow. Clean air hoods must be certified at least annually;

(I) Performs stringent quality control procedures, including complete sterile compounding records of drug lot number, expiration date, quantity used, and a copy of the label attached to the final compounded product;

(J) Is licensed by the board; and

(K) Meets other requirements as the board may determine are necessary to assure the safe and effective provision of home intravenous drug therapy services and the efficient administration of home intravenous drug therapy; and

(3) “Referring physician” means, with respect to providing home intravenous drug therapy services to an individual, a physician who:

(A) Prescribed the home intravenous drug for which the services are to be provided; and

(B) Established the plan of care for the services.

**History.** Acts 1993, No. 918, § 1; 2003, No. 1473, § 45.

SUBCHAPTER 9 — MEDICAID FRAUD FALSE CLAIMS ACT

SECTION.

20-77-901. Definitions.

20-77-902. Liability for certain acts.

20-77-911. Persons providing information

regarding Medicaid fraud  
— Rewards.

**Effective Dates.** Acts 2003, No. 1163, § 2: Apr. 8, 2003. Emergency clause provided: “It is found and determined by the General Assembly of the State of Arkansas that the Medicaid Fraud False Claims Act is in immediate need of these revisions to clarify an ambiguity in the law; that the provisions of this act are essential to the successful operation and activities

of the Medicaid Fraud Control Unit and the Department of Human Services. Therefore, an emergency is declared to exist and this act being immediately necessary for the preservation of the public peace, health, and safety shall become effective on: (1) The date of its approval by the Governor; (2) If the bill is neither approved nor vetoed by the Governor, the

expiration of the period of time during which the Governor may veto the bill; or (3) If the bill is vetoed by the Governor and the veto is overridden, the date the last house overrides the veto.”

Acts 2003, No. 1473, § 74: July 1, 2003. Emergency clause provided: “It is found and determined by the General Assembly of the State of Arkansas that this act includes technical corrects to Act 923 of 2003 which establishes the classification and compensation levels of state employees covered by the provisions of the Uniform Classification and Compensation Act; that Act 923 of 2003 will become effective on July 1, 2003; and that to avoid confusion this act must also [sic] effective on July 1, 2003. Therefore, an emergency is declared to exist and this act being necessary for the preservation of the public peace, health, and safety shall become effective on July 1, 2003.”

Acts 2011, No. 1154, § 3: Apr. 4, 2011. Emergency clause provided: “It is found and determined by the General Assembly

of the State of Arkansas that the statutes authorizing procedures for the recovery of false or fraudulent Medicaid claims are in immediate need of this revision to encourage citizens of the state to help recover public funds and Medicaid moneys that have been wrongfully misappropriated and will otherwise be lost forever; and that the provisions of this act are essential to successful operations and activities of the Medicaid Fraud Control Unit of the Attorney General’s office and the Department of Human Services. Therefore, an emergency is declared to exist and this act being immediately necessary for the preservation of the public peace, health, and safety shall become effective on: (1) The date of its approval by the Governor; (2) If the bill is neither approved nor vetoed by the Governor, the expiration of the period of time during which the Governor may veto the bill; or (3) If the bill is vetoed by the Governor and the veto is overridden, the date the last house overrides the veto.”

## 20-77-901. Definitions.

As used in this subchapter:

(1) “Arkansas Medicaid program” means the program authorized under Title XIX of the federal Social Security Act, which provides for payments for medical goods or services on behalf of indigent families with dependent children and of aged, blind, or disabled individuals whose income and resources are insufficient to meet the cost of necessary medical services;

(2) “Claim” includes any request or demand, including any and all documents or information required by federal or state law or by rule, made against medical assistance programs funds for payment. A claim may be based on costs or projected costs and includes any entry or omission in a cost report or similar document, book of account, or any other document which supports, or attempts to support, the claim. A claim may be made through electronic means if authorized by the Department of Human Services. Each claim may be treated as a separate claim, or several claims may be combined to form one claim.

(3) “Fiscal agent” means any individual, firm, corporation, professional association, partnership, organization, or other legal entity which, through a contractual relationship with the department, the State of Arkansas receives, processes, and pays claims under the program;



(4) "Knowing" or "knowingly" means that the person has actual knowledge of the information or acts in deliberate ignorance or reckless disregard of the truth or falsity of the information;

(5) "Medicaid recipient" means any individual on whose behalf any person claimed or received any payment or payments from the program or its fiscal agents, whether or not the individual was eligible for benefits under the program;

(6) "Person" means any provider of goods or services or any employee of the provider, whether that provider be an individual, individual medical vendor, firm, corporation, professional association, partnership, organization, or other legal entity under the program but which provides goods or services to a provider under the program or its fiscal agents; and

(7) "Records" means all documents in any form, including, but not limited to, medical documents and X rays, prepared by any person for the purported provision of any goods or services to any Medicaid recipient.

**History.** Acts 1993, No. 1299, § 1;  
1999, No. 1544, § 6; 2003, No. 1473, § 46.

## **20-77-902. Liability for certain acts.**

A person shall be liable to the State of Arkansas, through the Attorney General, for a civil penalty and restitution if he or she:

(1) Knowingly makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under the Arkansas Medicaid program;

(2) At any time knowingly makes or causes to be made any false statement or representation of a material fact for use in determining rights to a benefit or payment;

(3) Having knowledge of the occurrence of any event affecting his or her initial or continued right to any benefit or payment or the initial or continued right to any benefit or payment of any other individual in whose behalf he or she has applied for or is receiving a benefit or payment knowingly conceals or fails to disclose that event with an intent fraudulently to secure the benefit or payment either in a greater amount or quantity than is due or when no benefit or payment is authorized;

(4) Having made application to receive any benefit or payment for the use and benefit of another and having received it, knowingly converts the benefit or payment or any part thereof to a use other than for the use and benefit of the other person;

(5) Knowingly presents or causes to be presented a claim for a physician's service for which payment may be made under the program and knows that the individual who furnished the service was not licensed as a physician;

(6) Knowingly solicits or receives any remuneration, including any kickback, bribe, or rebate, directly or indirectly, overtly or covertly, in cash or in kind:

(A) In return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under the program; or

(B) In return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under the program;

(7)(A) Knowingly offers or pays any remuneration, including any kickback, bribe, or rebate, directly or indirectly, overtly or covertly, in cash or in kind to any person to induce the person:

(i) To refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under the program; or

(ii) To purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under the program.

(B) Subdivision (7)(A) of this section shall not apply to:

(i) A discount or other reduction in price obtained by a provider of services or other entity under the program if the reduction in price is properly disclosed and appropriately reflected in the costs claimed or charges made by the provider or entity under the program;

(ii) Any amount paid by an employer to an employee who has a bona fide employment relationship with the employer for employment in the providing of covered items or services; or

(iii) Any amount paid by a vendor of goods or services to a person authorized to act as a purchasing agent for a group of individuals or entities who are furnishing services reimbursed under the program, if:

(a) The person has a written contract with each individual or entity which specifies the amount to be paid the person, which amount may be a fixed amount or a fixed percentage of the value of the purchases made by each individual or entity under the contract; and

(b) In the case of an entity that is a provider of services as defined in § 20-9-101, the person discloses, in the form and manner as the Director of the Department of Human Services requires, to the entity and upon request to the director the amount received from each vendor with respect to purchases made by or on behalf of the entity; and

(iv) Any payment practice specified by the director promulgated pursuant to applicable federal or state law;

(8) Knowingly makes or causes to be made or induces or seeks to induce the making of any false statement or representation of a material fact:



(A) With respect to the conditions or operation of any institution, facility, or entity in order that the institution, facility, or entity may qualify either upon initial certification or upon recertification as a hospital, rural primary care hospital, skilled nursing facility, nursing facility, intermediate care facility for the mentally retarded, home health agency, or other entity for which certification is required; or

(B) With respect to information required pursuant to applicable federal and state law, rules, regulations, and provider agreements;

(9) Knowingly:

(A) Charges for any service provided to a patient under the program money or other consideration at a rate in excess of the rates established by the state; or

(B) Charges, solicits, accepts, or receives, in addition to any amount otherwise required to be paid under the program, any gift, money, donation, or other consideration other than a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to the patient as a precondition of admitting a patient to a hospital, nursing facility, or intermediate care facility for the mentally retarded or as a requirement for the patient's continued stay in the facility when the cost of the services provided therein to the patient is paid for in whole or in part under the program;

(10) Knowingly makes or causes to be made any false statement or representation of a material fact in any application for benefits or for payment in violation of the rules, regulations, and provider agreements issued by the program or its fiscal agents; or

(11) Knowingly:

(A) Participates, directly or indirectly, in the Arkansas Medicaid Program after having pleaded guilty or nolo contendere to or been found guilty of a charge of Medicaid fraud, theft of public benefits, or abuse of adults as defined in the Arkansas Criminal Code, § 5-1-101 et seq.; or

(B) As a certified health provider enrolled in the Arkansas Medicaid Program pursuant to Title XIX of the Social Security Act or the fiscal agent of such a provider who employs, engages as an independent contractor, engages as a consultant, or otherwise permits the participation in the business activities of such a provider, any person who has pleaded guilty or nolo contendere to or has been found guilty of a charge of Medicaid fraud, theft of public benefits, or abuse of adults as defined in the Arkansas Criminal Code, § 5-1-101 et seq.

**History.** Acts 1993, No. 1299, § 2; Security Act, referred to in this section, is 2003, No. 1163, § 1. codified as 42 U.S.C.S. § 1396 et seq.

**U.S. Code.** Title XIX of the Social

## RESEARCH REFERENCES

**U. Ark. Little Rock L. Rev.** Survey of Medicaid Fraud Conviction, 26 U. Ark. Little Rock L. Rev. 465.  
 Legislation, 2003 Arkansas General Assembly, Public Health and Welfare, Med-

## CASE NOTES

**In General.**

Impropriety requirement for tortious interference was not satisfied by the health services company's violation of the federal anti-kickback statute, 42 U.S.C.S. § 1320a-7b(b), and comparable Arkansas statutes, the Arkansas Medicaid Fraud Act, § 5-55-111, and the Arkansas Medicaid Fraud False Claims Act, § 20-77-902; even though the company's policy, which

denied privileges to doctors who acquired or held an interest in a competitor hospital, created a disincentive for the doctors to maintain ownership in a competing hospital, the policy did not create a disincentive for them to refer their patients to facilities other than the company's hospitals. *Baptist Health v. Murphy*, 365 Ark. 115, 226 S.W.3d 800 (2006).

**20-77-911. Persons providing information regarding Medicaid fraud — Rewards.**

(a) The court is authorized to pay a person sums, not exceeding ten percent (10%) of the aggregate penalty recovered, as it may deem just, for information the person may have provided which led to the detecting and bringing to trial and punishment persons guilty of violating the Medicaid fraud laws.

(b) Upon disposition of any civil action relating to violations of this subchapter in which a penalty is recovered, the Attorney General may petition the court on behalf of a person who may have provided information that led to the detecting and bringing to trial and punishment persons guilty of Medicaid fraud to reward the person in an amount commensurate with the quality of information determined by the court to have been provided, in accordance with the requirements of this subchapter.

(c)(1) If the Attorney General elects not to petition the court on behalf of the person, the person may petition the court on his or her own behalf.

(2) Neither the state nor any defendant within the action shall be liable for expenses that a person incurs in bringing an action under this section.

(d) An employee or a fiscal agent charged with the duty of referring or investigating cases of Medicaid fraud who is employed by or who contracts with any governmental entity shall not be eligible to receive a reward under this section.

**History.** Acts 1993, No. 1299, § 11; 2011, No. 1154, § 1; 2013, No. 1132, § 50.

**Amendments.** The 2011 amendment rewrote the section heading; and deleted "or in any case not more than one hundred thousand dollars (\$100,000)" following "the aggregate penalty recovered" in (a).

The 2013 amendment, in (d), substituted "An employee" for "Employees," "agent" for "agents," "is" for "are," and "contracts" for "contract" and inserted "a" following "An employee or."



**SUBCHAPTER 11 — ARKIDS FIRST PROGRAM ACT**

## SECTION.

20-77-1104. Waiver — Rules.

**20-77-1104. Waiver — Rules.**

(a) As used in this section:

(1)(A) “Health care coverage” means health care insurance regulated by the State Insurance Department, including without limitation group and employer-sponsored health insurance plans.

(B) The Department of Human Services may by rule exclude other plans or coverage from the definition of health care coverage;

(2) “Parity for mental health care” means coverage for the diagnosis and mental health treatment of mental illnesses and the mental health treatment of individuals with developmental disabilities under the same terms and conditions as provided for covered benefits offered under the program for the treatment of other medical illnesses or conditions and with no differences in the program in regard to any of the following:

(A) The duration or frequency of coverage;

(B) The dollar amount of coverage; or

(C) Financial requirements; and

(3) “Program” means the ARKids First Program.

(b) The Department of Human Services shall administer the program.

(c)(1) The Department of Human Services shall not enroll any population defined in this section until the Department of Human Services has sought and obtained approval from the Centers for Medicare &amp; Medicaid Services necessary to allow the use of matching federal funds to provide program services to that population.

(2) The Department of Human Services shall apply to the Centers for Medicare &amp; Medicaid Services for approval to enroll the populations defined in subdivisions (d)(4)(B) and (C) of this section.

(d) The Department of Human Services shall administer and promulgate rules for the program in a manner that:

(1) Provides for the automatic assignment of medical payments due under §§ 20-77-302 and 20-77-307 as a condition of eligibility for benefits under the uninsured children’s program;

(2) Defines the services to be covered under the program, including without limitation parity for outpatient mental health care;

(3) Establishes a copayment for services received in the program as determined through rules adopted by the Department of Human Services;

(4) Defines the population which may receive services provided or reimbursed through this program within the following limitations:

(A) Children eighteen (18) years of age or younger without health care coverage who are members of a family with a gross family income not exceeding two hundred fifty percent (250%) of the federal poverty guidelines;

(B) Persons nineteen (19) years of age or older but less than twenty-one (21) years of age who:

- (i) Are without health care coverage;
- (ii) Are members of a family with a gross family income not exceeding two hundred fifty percent (250%) of the federal poverty guidelines;
- (iii) Are enrolled as full-time students in a public or private college, university, technical institute, technical college, or other institution of higher education located in the state; and
- (iv) Are covered under the program under subdivision (d)(4)(A) on the day before becoming age nineteen (19); or

(C) Persons twenty-one (21) years of age or older but less than twenty-five (25) years of age who:

- (i) Are without health care coverage;
- (ii) Are members of a family with a gross family income not exceeding two hundred fifty percent (250%) of the federal poverty guidelines;
- (iii) Are enrolled as full-time students in a public or private college, university, technical institute, technical college, or other institution of higher education located in the state; and
- (iv) Are covered under the program under subdivision (d)(4)(A) of this section on the day before becoming age twenty-one (21).

(e) A person enrolled in the full Medicaid program shall not be concurrently enrolled in the program except as required by federal law.

(f)(1) Subdivisions (d)(4)(B) and (C) of this section apply only to students who enroll as students in a public or private college, university, technical institute, technical college, or other institution of higher education no less than six (6) months after graduation from high school and who maintain a continuous enrollment each consecutive semester thereafter with no periods of time in which the person is not enrolled as a student, excluding regularly scheduled summer breaks.

(2) If a person who has enrolled in the program under subsection (d)(4)(B) or (C) is not enrolled as a student as set forth in subdivision (f)(1) of this section, the person shall not be entitled to health care coverage under the program and shall not be entitled to later resume coverage following a break in eligibility.

(g) Providers of covered services shall be enrolled as Medicaid providers, and reimbursement shall be at the rates established by the program.

**History.** Acts 1999, No. 849, § 4; 2001, No. 747, § 1; 2003, No. 552, § 1; 2009, No. 435, § 1.

**Amendments.** The 2009 amendment rewrote the section.



## SUBCHAPTER 12 — MEDICAID PROGRAM FOR LOW-INCOME DISABLED WORKING PERSONS

### SECTION.

20-77-1203. Definitions.

20-77-1204. Administration — Regulation.

### 20-77-1203. Definitions.

As used in this subchapter, unless the context otherwise requires:

(1)(A) "Cost sharing" means the portion of the cost of a Medicaid-covered service which must be paid at the point of service by the eligible individual.

(B) Cost sharing shall be set on a sliding scale based on income;

(2) "Eligible individual" means an individual who meets the disability assets and unearned income standards to receive supplemental security income, who would be considered to be receiving supplemental security income benefits but for his or her earned income;

(3) "Family" means family as defined in the Medical Services Policy Manual;

(4) "Medicaid-covered service" means physician, pharmacy, and hospital services covered for other categories of the Arkansas Medicaid program; and

(5) "Premium" means a charge which must be paid by an applicant as a condition of enrolling in the low-income disabled working person category of Medicaid eligibility.

**History.** Acts 1999, No. 1197, § 3; 2013, No. 1048, § 1.

**A.C.R.C. Notes.** Acts 2013, No. 1048, § 3, provided:

"(a) The Department of Human Services shall adopt rules to implement this section.

"(b) If necessary, the department shall apply for a waiver from the Centers for

Medicare and Medicaid Services for approval of the rules adopted under this section."

**Amendments.** The 2013 amendment deleted "and whose not combined family income is less than two hundred fifty percent (250%) of the federal poverty guideline" from the end of (2).

### 20-77-1204. Administration — Regulation.

(a) The Department of Human Services is authorized to apply to the Centers for Medicare & Medicaid Services for approval to create and administer the low-income disabled working person category of Medicaid eligibility.

(b) The department shall promulgate rules for and administer the low-income disabled working person category of Medicaid eligibility in conformity with this subchapter with a state Medicaid plan amendment or waiver approved by the administration and in a manner that:

(1) Limits the population that may enroll in the low-income disabled working person category of Medicaid eligibility to eligible persons;

(2) Establishes premium and cost-sharing charges on a sliding scale based on income;

(3) Limits the services reimbursed to Medicaid-covered services furnished by providers enrolled as Medicaid providers;

(4) Limits reimbursements to the rates established by the department; and

(5) Provides for the automatic assignment of medical payments due as set out in §§ 20-77-302 and 20-77-307 as a condition of eligibility for benefits under the low-income disabled working person category of Medicaid eligibility.

(c) A rule adopted under this section shall not include a test for income, assets, or resources.

**History.** Acts 1999, No. 1197, § 4; 2013, No. 1048, § 2.

**A.C.R.C. Notes.** Acts 2013, No. 1048, § 3, provided:

“(a) The Department of Human Services shall adopt rules to implement this section.

“(b) If necessary, the department shall apply for a waiver from the Centers for Medicare and Medicaid Services for approval of the rules adopted under this section.”

**Amendments.** The 2013 amendment added (c).

SUBCHAPTER 14 — PRESCRIPTION DRUG ACCESS IMPROVEMENT ACT

20-77-1401. Title.

RESEARCH REFERENCES

U. Ark. Little Rock L. Rev. Survey of Legislation, 2001 Arkansas General Assembly, Public Health and Welfare, 24 U. Ark. Little Rock L. Rev. 557.

SUBCHAPTER 15 — COMMUNITY-BASED HEALTH CARE ACCESS PROGRAMS

SECTION.

- 20-77-1501. Legislative findings and intent.
- 20-77-1502. Definitions.
- 20-77-1503. Program administration — Member agreements.
- 20-77-1504. Coordination with local health education center programs.
- 20-77-1505. Donations by community-based health cooperatives.

SECTION.

- 20-77-1506. Program report.
- 20-77-1507. Community-based health cooperatives’ activity deemed not to be practice of medicine.
- 20-77-1508. Immunity and liability.
- 20-77-1509. Community-based health cooperative deemed not to be public utility or regulated industry.

**Effective Dates.** Acts 2003, No. 660, § 10: Mar. 26, 2003: “It is found and determined by the General Assembly of the State of Arkansas that the availability of a continuum of quality health care services, including preventive, primary, secondary, tertiary and long term care, is essential to the economic and social vitality of some communities; that in many communities access to health care ser-

vices is limited and the quality of health care services is negatively affected by inadequate financing, difficulty in recruiting and retaining skilled health professionals, and the migration of rural patients to urban areas for general acute care and specialty services; that the efficient and effective delivery of health care services to the uninsured requires the integration of public and private resources and the coor-



dination of health care providers; that currently state law does not provide the flexibility necessary to accomplish integration and coordination in a cost-effective manner; that the ability to create community-based health cooperatives to organize community-based health care programs and community-based health networks can help to alleviate many of the problems identified with the delivery of quality health care in many communities; that community-based health cooperatives and their programs and networks may serve as public laboratories to determine the best way of organizing health services so that the state can move closer to ensuring that everyone has access to health care while promoting cost containment efforts; that the immediate passage

of this act is necessary to continue to provide a statutory framework for the establishment of community-based health cooperatives to accomplish the objectives described in this act. Therefore, an emergency is declared to exist and this act being immediately necessary for the preservation of the public peace, health and safety shall become effective on: (1) The date of its approval by the Governor; (2) If the bill is neither approved nor vetoed by the Governor, it shall become effective on the expiration of the period of time during which the Governor may veto the bill; or (3) If the bill is vetoed by the Governor and the veto is overridden, it shall become effective on the date the last house overrides the veto."

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### **20-77-1501. Legislative findings and intent.**

(a) The General Assembly finds that:

(1) The State of Arkansas currently ranks forty-sixth among the fifty (50) states for having the least healthy population;

(2) A major contributing factor to the state's low health ranking is its high percentage of uninsured persons;

(3) There is a significant gap in the state's health care safety net, especially with regard to working adults with low incomes; and

(4) New relationships are needed between the federal and state governments, local communities, health care providers, employers, and uninsured persons in this state so that health care services for the uninsured will be more accessible, more affordable, and more effective.

(b) Therefore, there is created a statutory framework for the establishment of community-based health care access programs that can serve as a bridge to connect and assist government, communities, and citizens to develop a more comprehensive and responsible health care system, one that seeks to expand access and education with regard to health services for economically disadvantaged, uninsured working adults.

**History.** Acts 2003, No. 660, § 1.

### **20-77-1502. Definitions.**

As used in this subchapter:

(1) "Community-based" means based in, located in, or primarily relating to the community of geographically contiguous political subdivisions, as determined by the board of a community-based health cooperative, that will be or is served by the community-based health care access program initiated by the cooperative;

(2) “Community-based health care access program” means a program administered by a community-based health cooperative whereby hospital, medical, health education, and other health care services may be furnished by or through provider members of a community-based health network, or combination of networks, to uninsured residents of that community who are members of the program;

(3) “Community-based health cooperative” means a nonprofit corporation organized under the laws of this state that:

(A) Undertakes to establish, maintain, and operate a community-based health care access program; and

(B) Is governed by a board:

(i) With at least eighty percent (80%) of its members residing in the community; and

(ii) Including representatives of network providers; and

(4) “Community-based health network” means a contract-based network organized by a community-based health cooperative to provide or support the delivery of health care services to members served by the community-based health care access program.

**History.** Acts 2003, No. 660, § 2.

### **20-77-1503. Program administration — Member agreements.**

(a) A community-based health cooperative shall administer a community-based health care access program in a manner that:

(1) Defines the population that may receive subsidized services provided through the program by limiting program eligibility to adults between the ages of eighteen (18) and sixty-five (65) who:

(A) Are residing in or working in the community being served by the program;

(B) Are without health care coverage;

(C) Are not eligible for Medicare, Medicaid, or other similar government programs;

(D) Have an income not exceeding two hundred percent (200%) of the federal poverty level, as in effect January 1, 2003; and

(E) Meet any other requirements that, consistent with the purposes of this subchapter, are established by the board of directors of the community-based health cooperative;

(2) Defines the population that may receive unsubsidized services provided through the program by limiting program eligibility to adults between the ages of eighteen (18) and sixty-five (65) and their dependent children who:

(A) Are residing in or working in the community being served by the program;

(B) Are without health care coverage;

(C) Are not eligible for Medicare, Medicaid, ARKids First, or similar government programs;



(D) Have an income not exceeding three hundred percent (300%) of the federal poverty guidelines or are full-time employees of the cooperative; and

(E) Meet any other requirements that, consistent with the purposes of this subchapter, are established by the board;

(3) Provides for the automatic assignment of medical payments due the client member of the program to the cooperative as a condition of eligibility;

(4) Defines the services to be covered under the program; and

(5) Establishes copayments for services received by client members of the program.

(b) To promote the most efficient use of resources, cooperatives shall emphasize in client member agreements and provider member agreements:

(1) Disease prevention;

(2) Early diagnosis and treatment of medical problems; and

(3) Community care alternatives for individuals who would otherwise be at risk to be institutionalized.

(c)(1) A cooperative shall file with the Insurance Commissioner the program it develops.

(2) The filing with the commissioner shall be for review purposes only and shall neither require approval or disapproval by the commissioner.

(3) The information filed with the commissioner shall include an actuarial certification.

(4) For the purposes of this subsection, "actuarial certification" means a written statement by a member of the American Academy of Actuaries or other individuals acceptable to the commissioner that the program is actuarially sound based upon the person's examination, including a review of the appropriate records and methods utilized by the cooperative in establishing premium rates for the program.

**History.** Acts 2003, No. 660, § 3.

#### **20-77-1504. Coordination with local health education center programs.**

Whenever feasible, community-based health cooperatives shall participate actively with area health education center programs in developing and implementing recruitment, training, and retention programs directed at positively influencing the supply and distribution of health care professionals serving in or receiving training in rural health network areas.

**History.** Acts 2003, No. 660, § 4.

**20-77-1505. Donations by community-based health cooperatives.**

A community-based health cooperative may make donations for the public welfare or for charitable, scientific, or educational purposes, subject to such limitations, if any, as may be contained in its articles of incorporation or any amendment to the articles of incorporation.

**History.** Acts 2003, No. 660, § 5.

**20-77-1506. Program report.**

(a) In order to demonstrate program viability and effectiveness, a community-based health cooperative shall collect data and, upon request, make available a report to the appropriate interim committees of the Senate and House of Representatives.

(b) Data shall include:

- (1) The results of client member surveys;
- (2) The results of provider member surveys;
- (3) The results of community-need-assessment surveys; and
- (4) Other data as may be relevant to the community-based health care access program.

(c) The report shall include recommendations with regard to criteria and priorities for improvement and expansion of the program.

**History.** Acts 2003, No. 660, § 6.

**20-77-1507. Community-based health cooperatives' activity deemed not to be practice of medicine.**

No community-based health cooperative shall be deemed to be engaged in the corporate practice of medicine.

**History.** Acts 2003, No. 660, § 7.

**20-77-1508. Immunity and liability.**

No liability on the part of and no cause of action of any nature shall arise against any member of the board of directors of a community-based health cooperative or against an employee or agent of a cooperative for any lawful action taken by them in the performance of their administrative powers and duties under this subchapter.

**History.** Acts 2003, No. 660, § 8.

**20-77-1509. Community-based health cooperative deemed not to be public utility or regulated industry.**

(a)(1) Community-based health cooperatives shall not be considered or regulated as any type of entity governed by Title 23 of the Arkansas Code.



(2) No program offered by a cooperative shall be subject to regulation under Title 23 of the Arkansas Code.

(b) An entity subject to regulation under Title 23 of the Arkansas Code that contracts with a cooperative to provide or to arrange for the provision of secondary or tertiary services to client members of a community-based health care access program may not be required to comply with any provision of Title 23 of the Arkansas Code that mandates the provision of certain benefits, mandates the provision of a certain level of benefits, or both, regarding client members of a program. The exemption from regulation under Title 23 of the Arkansas Code shall apply only to the entity’s contracts with or services provided to the cooperative, and in all other instances, the entity is subject to the provisions of Title 23 of the Arkansas Code.

**History.** Acts 2003, No. 660, § 9.  
**Cross References.** Regulation of health care providers, § 23-99-101 et seq.

SUBCHAPTER 16 — ARKANSAS YOUTH SUICIDE PREVENTION ACT

SECTION.	SECTION.
20-77-1601. Title.	20-77-1606. Task force — Meetings.
20-77-1602. Legislative findings.	20-77-1607. Advisory Council to the Arkansas Youth Suicide Prevention Task Force — Creation.
20-77-1603. Purpose.	
20-77-1604. Arkansas Youth Suicide Prevention Task Force — Creation.	20-77-1608. Advisory council — Mission.
20-77-1605. Task force — Mission.	

20-77-1601. Title.

This subchapter shall be known and may be cited as the “Arkansas Youth Suicide Prevention Act”.

**History.** Acts 2005, No. 1757, § 1.

20-77-1602. Legislative findings.

- (a) The General Assembly finds that youth suicide is a serious problem that:
- (1) Takes the life of a youngster who has only begun to live; and
  - (2) Can be prevented with suicide intervention strategies.
- (b) The General Assembly also recognizes that suicide is the third leading cause of death for young people between the ages of fifteen (15) and twenty-four (24) and the fourth leading cause of death for persons between the ages of ten (10) and fourteen (14).

**History.** Acts 2005, No. 1757, § 1.

**20-77-1603. Purpose.**

The purpose of this subchapter is to establish:

(1) A task force made up of youth students, classroom teachers, and school counselors that addresses issues related to the prevention of youth suicide in an age group that is most vulnerable to depression; and

(2) An advisory council to provide the task force with scientifically based information on youth suicide, including suicide prevention best practices programs and recommendations for the implementation of proven suicide prevention programs for young people in the State of Arkansas.

**History.** Acts 2005, No. 1757, § 1.

**20-77-1604. Arkansas Youth Suicide Prevention Task Force — Creation.**

(a) There is established the Arkansas Youth Suicide Prevention Task Force.

(b) The task force shall consist of seventeen (17) members as follows:

(1)(A) The Governor shall appoint eight (8) members:

(i) Two (2) students who are in grades seven (7) or eight (8) at the time of appointment;

(ii) Two (2) students who are in grades nine through twelve (9-12) at the time of appointment; and

(iii) Four (4) students who attend an institution of higher education in the state.

(B) Each student appointed under subdivision (b)(1)(A) of this section shall reside in and represent a different University of Arkansas for Medical Sciences health education center region;

(2) The Governor shall appoint two (2) members who are classroom teachers;

(3) The Governor shall appoint two (2) members who are school counselors;

(4) The President Pro Tempore of the Senate shall appoint two (2) members who represent the state at large:

(A) One (1) student who is in grades nine through twelve (9-12) at the time of appointment; and

(B) One (1) student who attends an institution of higher education in the state; and

(5) The Speaker of the House of Representatives shall appoint two (2) members who represent the state at large:

(A) One (1) student who is in grades nine through twelve (9-12) at the time of appointment;

(B) One (1) student who attends an institution of higher education in the state; and

(6) The Attorney General or the Attorney General's designee.

(c)(1)(A) The Governor shall select student members from a list of interested students submitted to the Department of Education. Each student on the list shall have been recommended by the superinten-



dent of the school district in which the student attends school, by the governing body of the charter school or private school at which the student attends school, or by the president of the institution of higher education at which the student is enrolled.

(B) The Governor shall select student members to represent each of the following health education center regions:

- (i) Central;
- (ii) South central;
- (iii) North central;
- (iv) Northeast;
- (v) Northwest;
- (vi) Southwest;
- (vii) South; and
- (viii) Delta.

(C) Student members shall be at least thirteen (13) years of age but less than twenty-two (22) years of age when appointed.

(2) The Governor shall select the classroom teacher members from a list of interested teachers who are recommended by the Arkansas Education Association.

(3) The Governor shall select the school counselor members from a list of interested school counselors who are recommended by the Arkansas Counseling Association.

(4) All members shall be residents of the State of Arkansas at the time of appointment and throughout their terms.

(d)(1) In 2005, eight (8) members shall be appointed by the Governor to serve as follows:

- (A) Two (2) for terms to expire June 30, 2006;
- (B) Two (2) for terms to expire June 30, 2007;
- (C) Two (2) for terms to expire June 30, 2008; and
- (D) Two (2) for terms to expire June 30, 2009.

(2) In 2005, two (2) members shall be appointed by the Speaker of the House of Representatives to serve as follows:

- (A) One (1) for a term to expire June 30, 2006; and
- (B) One (1) for a term to expire June 30, 2007.

(3) In 2005, two (2) members shall be appointed by the President Pro Tempore of the Senate to serve as follows:

- (A) One (1) for a term to expire June 30, 2008; and
- (B) One (1) for a term to expire June 30, 2009.

(4) Subsequent appointments are for terms of two (2) years.

(e)(1) If a vacancy occurs in an appointed position for any reason, the vacancy shall be filled by appointment by the official who made the appointment.

(2) The new appointee shall serve for the remainder of the unexpired term.

**History.** Acts 2005, No. 1757, § 1.

**20-77-1605. Task force — Mission.**

The Arkansas Youth Suicide Prevention Task Force shall:

- (1) Assist in increasing the awareness of youth suicide among school personnel and community leaders;
- (2) Enhance the school climate and relationships among teachers, counselors, and students to encourage everyone to recognize the signs of suicidal tendencies and other facts about youth suicide;
- (3) Encourage the development and implementation of school-based youth suicide prevention programs and pilot projects;
- (4) Utilize community resources in the development and implementation of youth suicide prevention programs through cooperative efforts;
- (5) Increase the awareness of students of the relationship between drug and alcohol use and youth suicide;
- (6) Advocate programs to collect data on youth suicide attempts; and
- (7) Develop a program of suicide prevention for distribution to the schools of the State of Arkansas.

**History.** Acts 2005, No. 1757, § 1.

**20-77-1606. Task force — Meetings.**

(a)(1) The Arkansas Youth Suicide Prevention Task Force shall hold a meeting at least one (1) time during each quarter of the calendar year.

(2) The Commissioner of Education shall call the first meeting of the task force no later than thirty (30) days after all of the members are appointed to the task force.

(b)(1) At the first meeting, the task force shall determine by majority vote who shall serve as chair, vice chair, and secretary.

(2)(A) The task force shall elect officers annually at the first meeting of the task force in each calendar year.

(B) Officers shall serve one-year terms.

(c) A quorum shall consist of not fewer than nine (9) members. An affirmative vote of a quorum is necessary for the disposition of business.

(d) At the end of each calendar year, the task force shall submit a report to the commissioner.

(e)(1) The Department of Education shall provide staff and office space to the task force.

(2) The office space shall be in Little Rock, Arkansas.

(f)(1) Members shall receive no pay for services with respect to attendance at each meeting.

(2) However, if funds are appropriated for the purpose, members are entitled to expense reimbursement under § 25-16-902 for each day that the task force meets.

**History.** Acts 2005, No. 1757, § 1.



**20-77-1607. Advisory Council to the Arkansas Youth Suicide Prevention Task Force — Creation.**

(a) To assist the Arkansas Youth Suicide Prevention Task Force, there is established the Advisory Council to the Arkansas Youth Suicide Prevention Task Force.

(b) The advisory council shall consist of the following members:

(1) The Chair of the Department of Psychiatry of the University of Arkansas for Medical Sciences shall appoint two (2) members, one (1) of whom shall be designated as the chair of the advisory council;

(2) The Director of the Division of Behavioral Health Services shall appoint one (1) member from the Division of Behavioral Health Services;

(3) The Dean of the Fay W. Boozman College of Public Health of the University of Arkansas for Medical Sciences shall appoint one (1) member from the Department of Health Behavior and Health Education of the University of Arkansas for Medical Sciences;

(4) The Commissioner of Education shall appoint (1) member;

(5) The Chair of the Department of Psychiatry of the University of Arkansas for Medical Sciences shall appoint one (1) member from a list of three (3) persons submitted by the Arkansas office of the National Alliance on Mental Illness;

(6) The Chair of the Department of Psychiatry of the University of Arkansas for Medical Sciences shall appoint one (1) member from a list of three (3) persons submitted by the Board of Directors of Arkansas for Drug Free Youth; and

(7) The chair of the advisory council shall appoint one (1) interested parent from a list of interested parents who respond to a newspaper notice placed by the Department of Psychiatry of the University of Arkansas for Medical Sciences within thirty (30) days of August 12, 2005.

(c) Each member of the advisory council shall serve for a term of two (2) years.

(d)(1) If a vacancy occurs in an appointed position for any reason, the vacancy shall be filled by appointment by the official who made the appointment.

(2) The new appointee shall serve for the remainder of the unexpired term.

(e)(1) The advisory council shall meet at the times and places that the chair deems necessary, but no meetings shall be held outside the State of Arkansas.

(2)(A) Five (5) of the members of the advisory council shall constitute a quorum for the purpose of transacting business.

(B) All actions of the advisory council shall be by a quorum.

(f)(1) Members shall receive no pay for services with respect to attendance at each meeting.

(2) However, if funds are appropriated for the purpose, members are entitled to expense reimbursement under § 25-16-902 for each day that the advisory council meets.

**History.** Acts 2005, No. 1757, § 1.

**20-77-1608. Advisory council — Mission.**

The Advisory Council to the Arkansas Youth Suicide Prevention Task Force shall:

(1) Serve as a liaison between the Arkansas Youth Suicide Prevention Task Force and the scientific and treatment community to ensure that task force activities are firmly based in effective and safe suicide prevention activities;

(2) Research and make recommendations to the task force, the House Committee on Public Health, Welfare, and Labor, the Senate Committee on Public Health, Welfare, and Labor, and the General Assembly regarding successful youth suicide prevention programs used in other states;

(3) Develop a plan for a model youth suicide prevention program that can be implemented throughout the state with site-specific recommendations and recommend a timeline for the implementation of the model program;

(4)(A) If funds are appropriated for the purpose, host a conference with national experts in the field of youth suicide prevention.

(B) The Department of Psychiatry of the University of Arkansas for Medical Sciences shall coordinate the conference in conjunction with the task force.

(C) Invitees to the conference shall include students in grades seven through twelve (7-12), college students, teachers, professors, staff, and administrators of public schools, private schools, and institutions of higher education, mental health professionals, legislators, and other interested persons;

(5) Monitor and disburse appropriations for the task force, the advisory council, and related activities;

(6) Apply for, receive, and disburse grants related to youth suicide prevention and research as the advisory council deems appropriate; and

(7) Participate in the quarterly meetings of the task force.

**History.** Acts 2005, No. 1757, § 1; deleted “Interim” twice following “House” 2013, No. 1132, § 51.

**Amendments.** The 2013 amendment

and “Senate” in (2).

**SUBCHAPTER 17 — MEDICAID FAIRNESS ACT**

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**Effective Dates.** Acts 2005, No. 1758, § 2: Apr. 5, 2005. Emergency clause provided: “It is found and determined by the General Assembly of the State of Arkansas that Medicaid providers are frustrated in their attempts to access the appeals process and to interact with the Medicaid program, and that it is imperative that changes be made in state law to remedy these problems. Therefore, an emergency is declared to exist and this act being immediately necessary for the preservation of the public peace, health, and safety shall become effective on: (1) The date of its approval by the Governor; (2) If the bill is neither approved nor vetoed by the Governor, the expiration of the period of time during which the Governor may veto the bill; or (3) If the bill is vetoed by the Governor and the veto is overridden, the date the last house overrides the veto.”

Acts 2007, No. 596, § 8: Mar. 28, 2007. Emergency clause provided: “It is found and determined by the General Assembly of the State of Arkansas that clarifications are needed in order for Medicaid providers to gain access to the appeals process and to interact with the Medicaid program as envisioned under the Medicaid Fairness Act; and that it is imperative that changes be made in state law to remedy these problems. Therefore, an emergency is declared to exist and this act being immediately necessary for the preservation of the public peace, health, and safety shall become effective on: (1) The date of its approval by the Governor; (2) If the bill is

neither approved nor vetoed by the Governor, the expiration of the period of time during which the Governor may veto the bill; or (3) If the bill is vetoed by the Governor and the veto is overridden, the date the last house overrides the veto.”

Acts 2013, No. 562, § 8: Emergency clause failed to pass. Emergency clause provided: “It is found and determined by the General Assembly of the State of Arkansas that clarifications and changes in state law are needed for Medicaid providers to have a fair appeals process and to interact with the Medicaid program as envisioned under the Medicaid Fairness Act. It is further found and determined that Medicaid providers are entitled to a fair and impartial hearing with a neutral decision maker, that the most effective and efficient way to accomplish this is to utilize administrative law judges hired through the Department of Health to hear all provider appeals under the act, and that subdivision 20-77-1704(b)(1)(C) becomes effective on July 1, 2013. Therefore, an emergency is declared to exist, and this act being immediately necessary for the preservation of the public peace, health, and safety shall become effective on: (1) The date of its approval by the Governor; (2) If the bill is neither approved nor vetoed by the Governor, the expiration of the period of time during which the Governor may veto the bill; or (3) If the bill is vetoed by the Governor and the veto is overridden, the date the last house overrides the veto.”

**20-77-1701. Legislative findings and intent.**

- (a) The General Assembly finds that:
  - (1) Health care providers who serve Medicaid recipients are an indispensable and vital link in serving this state’s needy citizens; and

(2) The Department of Human Services already has in place various provisions to:

(A) Ensure the protection and respect for the rights of Medicaid recipients; and

(B) Sanction errant Medicaid providers when necessary.

(b) The General Assembly intends this subchapter to ensure that the department and its outside contractors treat providers with fairness and due process.

**History.** Acts 2005, No. 1758, § 1.

## **20-77-1702. Definitions.**

As used in this subchapter:

(1) “Abuse” means a pattern of provider conduct that is inconsistent with sound fiscal, business, or medical practices and that results in:

(A) An unnecessary cost to the Medicaid program; or

(B) Reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care;

(2)(A) “Adverse decision” means any decision by the Department of Human Services or its reviewers or contractors that adversely affects a Medicaid provider or recipient in regard to:

(i) Receipt of and payment for Medicaid claims and services, including, but not limited to, decisions as to:

(a) Appropriate level of care or coding;

(b) Medical necessity;

(c) Prior authorization;

(d) Concurrent reviews;

(e) Retrospective reviews;

(f) Least restrictive setting;

(g) Desk audits;

(h) Field audits and onsite audits; and

(i) Inspections or surveys; and

(ii) Payment amounts due to or from a particular provider resulting from gain sharing, risk sharing, incentive payments, or another reimbursement mechanism or methodology, including calculations that affect or have the potential to affect payment.

(B) To constitute an adverse decision, an agency decision need not have a monetary penalty attached but must have a direct monetary consequence to the provider.

(C) “Adverse decision” does not include the design of or changes to an element of a reimbursement methodology or payment system that is of general applicability and implemented through the rule-making process;

(3) “Appeal” means an appeal of an adverse decision to an independent administrative law judge as provided under this subchapter;

(4) “Claim” means a request for payment of services or for prior, concurrent, or retrospective authorization to provide services;



(5) "Concurrent review" or "concurrent authorization" means a review to determine whether a specified recipient currently receiving specific services may continue to receive services;

(6) "Denial" means denial or partial denial of a claim;

(7) "Department" means:

(A) The Department of Human Services;

(B) All the divisions and programs of the department, including the state Medicaid program; and

(C) All the department's contractors, fiscal agents, and other designees and agents;

(8) "Final determination" means a Medicaid overpayment determination:

(A) For which all provider appeals have been exhausted; or

(B) That cannot be appealed or appealed further by the provider because the time to file an appeal has passed;

(9) "Fraud" means an intentional representation that is untrue or made in disregard of its truthfulness for the purpose of inducing reliance in order to obtain or retain anything of value under the Medicaid program;

(10) "Level of care" means:

(A) The level of licensure or certification of the caregiver that is required to provide medically necessary services, for example, a physician or a registered nurse; and

(B) As applicable to the adverse decision:

(i) With respect to medical assistance reimbursed by procedure code or unit of service, the quantity of each medically necessary procedure or unit;

(ii) With respect to durable medical equipment, the type of equipment required and the duration of equipment use;

(iii) With respect to all other medical assistance, the:

(a) Intensity of service, for example, whether intensive care unit hospital services were required;

(b) Duration of service, for example, the number of days of a hospital stay; or

(c) Setting in which the service is delivered, for example, inpatient or outpatient;

(11) "Medicaid" means the medical assistance program under Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq., and Title XXI of the Social Security Act, § 1397aa et seq. that is operated by the department, including contractors, fiscal agents, and all other designees and agents;

(12) "Person" means any individual, company, firm, organization, association, corporation, or other legal entity;

(13) "Primary care physician" means a physician whom the department has designated as responsible for the referral or management, or both, of a Medicaid recipient's health care;

(14) "Prior authorization" means the approval by the state Medicaid program for specified services for a specified Medicaid recipient before

the requested services may be performed and before payment will be made by the state Medicaid program;

(15) "Provider" means a person enrolled to provide health or medical care services or goods authorized under the state Medicaid program;

(16) "Recoupment" means any action or attempt by the department to recover or collect Medicaid payments already made to a provider with respect to a claim by:

(A) Reducing other payments currently owed to the provider;

(B) Withholding or setting off the amount against current or future payments to the provider;

(C) Demanding payment back from a provider for a claim already paid; or

(D) Reducing or affecting in any other manner the future claim payments to the provider;

(17) "Retrospective review" means the review of services or practice patterns after payment, including, but not limited to:

(A) Utilization reviews;

(B) Medical necessity reviews;

(C) Professional reviews;

(D) Field audits and onsite audits; and

(E) Desk audits;

(18) "Reviewer" means any person, including, but not limited to, reviewers, auditors, inspectors, and surveyors, who in reviewing a provider or a provider's provision of medical assistance, reviews without limitation:

(A) Quality;

(B) Quantity;

(C) Utilization;

(D) Practice patterns;

(E) Medical necessity; and

(F) Compliance with Medicaid laws, regulations, and rules; and

(19)(A) "Technical deficiency" means an error or omission in documentation by a provider that does not affect direct patient care of the recipient.

(B) "Technical deficiency" does not include:

(i) Lack of medical necessity according to professionally recognized local standards of care;

(ii) Failure to provide care of a quality that meets professionally recognized local standards of care;

(iii) Failure to document a mandatory quality measure required for gain sharing or medical home or health home incentive payments as specified in a reimbursement mechanism or methodology;

(iv) Failure to obtain prior or concurrent authorization if required by regulation;

(v) Fraud;

(vi) Abuse;

(vii) A pattern of noncompliance; or

(viii) A gross and flagrant violation.



**History.** Acts 2005, No. 1758, § 1; 2007, No. 596, § 1; 2013, No. 562, §§ 1, 2, 3. rewrote (2) and (3); inserted “and Title XXI” in (11); and inserted (19)(B)(iii) and redesignated the remaining subdivisions accordingly.

**Amendments.** The 2013 amendment

### 20-77-1703. Recoupment.

(a)(1) The Department of Human Services shall not use a technical deficiency as grounds for recoupment unless identifying the technical deficiency as an overpayment is mandated by a specific federal statute or regulation or the state is required to repay the funds to the Centers for Medicare & Medicaid Services, or both.

(2) When recoupment is permitted, the department shall not recoup until there is a final determination identifying the funds to be recouped as overpayments.

(b)(1) The department shall recognize that an error or omission is a technical deficiency if:

(A) The error or omission meets the definition of “technical deficiency” in § 20-77-1702;

(B) The error or omission involved a covered service; and

(C) The provider can substantiate through other documentation that the medical assistance was provided.

(2) Other documentation under subdivision (b)(1)(C) of this section shall be:

(A) In accord with generally accepted health care practices; and

(B) Contemporaneously created.

(3) Other documentation under subdivision (b)(1)(C) of this section is not required to be equivalent in form to nor required to duplicate the documentation containing the error or omission, if all the documentation taken together establishes that the claim is payable.

(c) This section does not preclude a corrective action plan or other nonmonetary measure in response to technical deficiencies.

(d)(1) If a provider fails to comply with a corrective action plan for a pattern of technical deficiencies, then appropriate monetary penalties may be imposed if permitted by law.

(2) However, the department first must be clear as to what the technical deficiencies are by providing clear communication in writing or a promulgated rule when required.

(e) The department shall not issue a recoupment on a minor omission such as a missing date or signature if the requirements of this section are met.

(f) The department shall not rely on the denial of one (1) claim as the sole basis for the denial of a subsequent claim and shall establish that the subsequent claim is deficient.

**History.** Acts 2005, No. 1758, § 1; 2007, No. 596, § 1; 2009, No. 952, § 17; 2013, No. 562, § 4. inserted “The error or omission” in (b)(1)(B), and made a related change.

**Amendments.** The 2009 amendment substituted “Recoupment” for “Technical deficiencies” in

the section heading; rewrote the introductory language of (b)(2); and added (b)(3), (e) and (f).

#### **20-77-1704. Provider administrative appeals allowed.**

(a) The General Assembly finds it necessary to:

(1) Clarify its intent that providers have the right to fair and impartial administrative appeals; and

(2) Emphasize that this right of appeal is to be liberally construed and not limited through technical or procedural arguments by the Department of Human Services.

(b)(1)(A) In response to an adverse decision, a provider may appeal on behalf of the recipient or on its own behalf, or both, regardless of whether the provider is an individual or a corporation.

(B)(i) A provider appeal shall be governed by the Arkansas Administrative Procedure Act, § 25-15-201 et seq., except as otherwise provided in this subchapter.

(ii) Multiple appeals by the same provider may be consolidated.

(C) An administrative law judge employed by the Department of Health shall conduct all Medicaid provider administrative appeals of adverse decisions under this subchapter.

(2) The provider may appear:

(A) In person or through a corporate representative; or

(B) With prior notice to the department, through legal counsel.

(3)(A) A Medicaid recipient may attend any hearing related to his or her care, but the department may not make his or her participation a requirement for provider appeals.

(B) The department may compel the recipient's presence via subpoena, but failure of the recipient to appear shall not preclude the provider appeal.

(c)(1) An administrative law judge shall be guided by the need to reach a just determination and may depart from strict adherence to the formal rules of evidence.

(2) An administrative law judge shall exclude irrelevant, immaterial, and unduly repetitious evidence.

(3) An administrative law judge shall receive oral or documentary evidence not privileged if the oral or documentary evidence is of a type commonly relied upon by a reasonably prudent person in the conduct of his or her affairs.

(4) An administrative law judge shall rule on each evidentiary objection, and the objection and ruling shall be noted of record.

(d)(1)(A) If a provider submits evidence that the Department of Human Services has not had an opportunity to consider before the hearing, an administrative law judge shall continue the hearing for thirty (30) days to allow the Department of Human Services to review the evidence.

(B) An administrative law judge may extend the thirty-day continuance under subdivision (d)(1)(A) of this section for good cause.



(2) Before the end of a continuation under subdivision (d)(1) of this section, the Department of Human Services shall send the provider and the administrative law judge notice stating whether the Department of Human Services will modify its decision with an explanation of the modification.

(3)(A) Unless the provider notifies the administrative law judge and the Department of Human Services that the provider wishes to withdraw its appeal, the administrative law judge shall notify the parties of the date and time at which the hearing will continue.

(B) The date under subdivision (d)(3)(A) of this section shall be no later than thirty (30) days after the Department of Human Services's notification under subdivision (d)(2) of this section.

(e) A provider does not have standing to appeal a decision denying payment or ordering recoupment of payments already made if the provider has not furnished any service for which payment has been denied.

(f)(1) Providers, like Medicaid recipients, have standing to appeal to circuit court unfavorable administrative decisions under the Arkansas Administrative Procedure Act, § 25-15-201 et seq.

(2) The Department of Human Services may seek judicial review of a final, appealable order issued by an administrative law judge.

(g) Burdens of proof shall be determined under the Arkansas Administrative Procedure Act, § 25-15-201 et seq.

(h)(1)(A) A final decision by an administrative law judge in favor of a provider is a final appealable order.

(B) A final decision under this section shall not be overturned by the Director of the Division of Medical Services of the Department of Human Services or another official within the Department of Human Services.

(2)(A) Within thirty (30) days after August 16, 2013, the Department of Human Services shall request a waiver from the Centers for Medicare & Medicaid Services of the single state agency requirement contained in 42 C.F.R. 431.10 to allow final decisions in Medicaid provider administrative appeals to be issued by an administrative law judge in a separate agency.

(B) An administrative law judge shall follow the rules adopted by the Department of Human Services in making final decisions.

(3) The Department of Human Services shall make available to the public all communications with regard to the waiver application under subdivision (h)(2)(A) of this section and shall work jointly with provider representatives to obtain and maintain approval for the waiver.

(i)(1) Until the waiver under subdivision (h)(2) of this section is approved, an administrative law judge's decision shall constitute a recommended decision to the Director of the Division of Medical Services.

(2)(A) The Director of the Division of Medical Services, upon a review of the record submitted by an administrative law judge, shall adopt, reject, or modify the recommended decision.

(B) A modification or rejection of an administrative law judge's decision shall state with particularity the reasons for the modification or rejection, shall include references to the record, and shall constitute the final decision.

(C) As an alternative to the process under subdivision (i)(2)(B) of this section, the Director of the Division of Medical Services may remand the decision to the administrative law judge with additional guidance on Medicaid policy.

(3)(A) The Director of the Division of Medical Services shall issue a final decision under this subsection within thirty (30) days after receipt of the administrative law judge's decision.

(B) Unless the Director of the Division of Medical Services modifies or rejects the recommended decision of the administrative law judge within thirty (30) days after receipt of the administrative law judge's decision, the recommended decision is the final decision.

(j) If an administrative appeal is filed by both provider and recipient concerning the same subject matter, then the department may consolidate the appeals.

(k)(1) This subchapter shall apply to all pending and subsequent appeals that have not been finally resolved at the administrative or judicial level as of April 5, 2005.

(2) The amendatory provisions of this act apply to a pending and subsequent appeal that has not been finally resolved at the administrative or judicial level on August 16, 2013.

**History.** Acts 2005, No. 1758, § 1; 2013, No. 562, § 4.

**Amendments.** The 2013 amendment inserted "fair and impartial" in (a)(1); deleted "under the Arkansas Administrative Procedure Act, § 25-15-201 et seq." in

(b)(1); added (b)(1)(B); inserted (c) and (d) and redesignated the remaining subsections accordingly; rewrote present (e); inserted (f)(2); inserted (g) through (i) and redesignated the remaining subsections accordingly; and added (k)(2).

## **20-77-1705. Explanations for adverse decisions required.**

Each denial or other deficiency that the Department of Human Services makes against a Medicaid provider shall be prepared in writing and shall specify:

- (1) The nature of the adverse decision;
- (2) The statutory provision or specific rule alleged to have been violated; and
- (3) The facts and grounds that form the basis for the adverse decision.

**History.** Acts 2005, No. 1758, § 1; 2007, No. 596, § 2.

## **20-77-1706. Reimbursement at an alternate level instead of complete denial.**

(a)(1)(A) Subject to § 20-77-1707 for retrospective reviews, if the Department of Human Services has sufficient documentation to



determine that some level of care other than the level that was claimed is medically necessary, then the department may recoup.

(B) However, the provider shall be entitled to file a second claim at the level that was medically necessary according to the department's explanation for recoupment.

(C) Alternatively, the department may recoup the difference between the amount previously paid and the amount that would be payable for the care deemed to be medically necessary.

(2)(A) If the department does not have sufficient documentation to determine the level of care that was medically necessary, the department shall not recoup at that time, but shall request from the provider additional documentation the department needs to determine the level of care that was medically necessary.

(B) After receiving documentation requested under subdivision (b)(2)(A) of this section, the department shall review the documentation and determine whether to proceed with a recoupment and notice, subject to § 20-77-1707.

(3)(A) No physician referral shall be required as a condition of payment for care that is determined to be medically necessary upon a review conducted under this section.

(B) A requirement for a referral from a primary care physician shall not be imposed retroactively.

(4)(A) The recoupment notice from the department under subdivisions (a)(1) and (2) of this section shall explain the reason for the recoupment under § 20-77-1705 and shall include one (1) of the following statements:

(i) "In the reviewer's professional judgment, the documentation submitted establishes that the following care, treatment, or evaluation was medically necessary: \_\_\_\_\_"; or

(ii) "In the reviewer's professional judgment, the documentation submitted does not establish that any care, service, or evaluation was medically necessary".

(B) For purposes of this subdivision (a)(4), "care" may include referrals to health care professionals.

(5) A provider's decision to file a second claim at the level of care approved by the reviewer or the department's decision to recoup rather than requiring a second claim does not waive the provider's or recipient's right to appeal the denial of the original claim if the provider disagrees with the department's determination.

(b)(1) For concurrent or prior authorization, if the department has sufficient documentation to establish that some level of care other than the requested level is medically necessary, the department shall approve the request at the other level of care with proper notice.

(2)(A) If the department does not have sufficient documentation to determine the level of care that is medically necessary, the department shall not deny the claim at that time but shall request from the provider the additional documentation the department needs to determine the level of care that is medically necessary.

(B) The department shall then:

(i) Review the request; and

(ii) If the department denies the request, explain the reason for the denial in accordance with subdivision (b)(4) of this section.

(3)(A) No physician referral shall be required as a condition of payment for care that is determined to be medically necessary upon a review conducted under this section.

(B) A requirement for a referral from a primary care physician shall not be imposed retroactively.

(4)(A) The denial notice from the department under subdivisions (b)(1) and (2) of this section shall explain the reason for the denial as required by § 20-77-1705 and shall include one (1) of the following statements:

(i) "In the reviewer's professional judgment, the documentation submitted establishes that the following care, treatment, or evaluation was medically necessary: \_\_\_\_\_"; or

(ii) "In the reviewer's professional judgment, the documentation submitted does not establish that any care, service, or evaluation was medically necessary".

(B) For purposes of this subdivision (b)(4), "care" may include referrals to health care professionals.

(5) The department's decision to approve a request at another level of care under this subsection does not remove the provider's or recipient's right to appeal the denial of the original claim if the provider disagrees with the department's determination.

(c)(1) Subsections (a) and (b) of this section apply only:

(A) In the absence of fraud or abuse; and

(B) If the care is furnished by a provider legally qualified and authorized to deliver the care.

(2) Nothing prevents the department from reviewing the claim for reasons unrelated to level of care and taking action that may be warranted by the review, subject to other provisions of law.

**History.** Acts 2005, No. 1758, § 1;  
2007, No. 596, § 2.

## **20-77-1707. Prior authorizations — Retrospective reviews.**

If the Department of Human Services requires a provider to justify the medical necessity of a service through prior authorization, the department shall not later take the position that the services were not medically necessary, unless the retrospective review establishes that:

(1) The previous authorization was based upon misrepresentation by act or omission;

(2) The services billed were not provided; or

(3) An unexpected change occurred that rendered the prior-authorized care not medically necessary.



**History.** Acts 2005, No. 1758, § 1; 2013, No. 562, § 5.

**A.C.R.C. Notes.** The 2013 amendment omitted "(B) If the facts had been known, the specific level of care would not have been authorized; or" in subdivision (1)

without striking through the language to indicate its repeal. It appears it was intended to be repealed by this act.

**Amendments.** The 2013 amendment rewrote the section.

### **20-77-1708. Medical necessity.**

(a) There is a presumption in favor of the medical judgment of the performing or prescribing physician in determining medical necessity of treatment.

(b) If an administrative law judge finds that the Department of Human Services has overcome the presumption under subsection (a) of this section, he or she shall state the manner by which the presumption was overcome.

**History.** Acts 2005, No. 1758, § 1; 2007, No. 596, § 3; 2013, No. 562, § 5. redesignated the former section as (a) and added (b).

**Amendments.** The 2013 amendment

### **20-77-1709. Promulgation before enforcement.**

(a) The Department of Human Services may not use state policies, guidelines, manuals, or other such criteria in enforcement actions against providers unless the criteria have been promulgated.

(b) Nothing in this section requires or authorizes the department to attempt to promulgate standards of care that practitioners use in determining medical necessity or rendering medical decisions, diagnoses, or treatment.

(c) Medicaid contractors may not use a different provider manual than the Medicaid provider manual promulgated for each service category.

**History.** Acts 2005, No. 1758, § 1; 2007, No. 596, § 4.

### **20-77-1710. Delivery of files.**

(a) If the Department of Human Services makes an adverse decision in a Medicaid case and a provider then lodges an administrative appeal, the department shall deliver to the provider well in advance of the appeal its file on the matter so that the provider will have time to prepare for the appeal.

(b) The file shall include the records of any utilization review contractor or other agent, subject to any other federal or state law regarding confidentiality restrictions.

**History.** Acts 2005, No. 1758, § 1.

**20-77-1711. Copies of records to be supplied to department — Exception.**

(a) Except as provided in subsection (b) of this section, providers must supply records to the Department of Human Services at their own cost.

(b) If the provider has supplied records to the department and the provider identifies to whom the records were supplied, the provider is not required to provide a second copy of the records at its own cost.

**History.** Acts 2005, No. 1758, § 1;  
2007, No. 596, § 5.

**20-77-1712. Notices.**

When the Department of Human Services sends letters or other forms of notice with deadlines to providers or recipients, the deadline shall not begin to run before the next business day following the date of the postmark on the envelope, the facsimile transmission confirmation sheet, or the electronic record confirmation, unless otherwise required by federal statute or regulation.

**History.** Acts 2005, No. 1758, § 1.

**20-77-1713. Deadlines.**

(a) The Department of Human Services may not issue a claim denial or demand for recoupment to providers for missing a deadline if the department or its contractor contributed to the delay or the delay was reasonable under the circumstances, including, but not limited to:

- (1) Intervening weekends or holidays;
- (2) Lack of cooperation by third parties;
- (3) Natural disasters; or
- (4) Other extenuating circumstances.

(b) This section is subject to good faith on the part of the provider.

**History.** Acts 2005, No. 1758, § 1.

**20-77-1714. Hospital claims.**

(a) When more than one (1) hospital provides services to a recipient and the amount of claims exceeds the recipient's benefit limit, then the hospitals are entitled to reimbursement based on the earliest date of service.

(b) If the claims have been paid by Medicaid contrary to this provision and voluntary coordination among the hospitals involved does not resolve the matter, then the hospitals shall resort to mediation or arbitration at the hospitals' expense.

**History.** Acts 2005, No. 1758, § 1;  
2007, No. 596, § 6.



**20-77-1715. Federal law.**

(a) If any provision of this subchapter is found to conflict with current federal law, including promulgated federal regulations, the federal law shall override that provision.

(b) If under Titles XIX of the Social Security Act, 42 U.S.C. § 1396 et seq., or Title XXI of the Social Security Act, § 1397aa et seq., the federal government recovers an erroneous or improper medical assistance payment from the Department of Human Services, the department may recover the erroneous or improper medical assistance payment from the provider that received the payment or from a successor in interest who is legally responsible for the erroneous or improper medical assistance payment.

**History.** Acts 2005, No. 1758, § 1; redesignated the former section as (a) and 2013, No. 562, § 6. added (b).

**Amendments.** The 2013 amendment

**20-77-1716. Promulgation of rules.**

The Department of Human Services may promulgate rules to implement this subchapter.

**History.** Acts 2007, No. 596, § 7.

**20-77-1717. Timelines for audits.**

(a) If a Medicaid provider audit by the Medicaid Integrity Program or Audit Medicaid Integrity Contractors is conducted, the Department of Human Services or the contractor shall provide the audit report to the provider within one hundred fifty (150) days after the completion of the audit field work.

(b) If a provider requests an administrative reconsideration of an audit finding or report, the department shall provide the results of the reconsideration within sixty (60) days after the department's receipt of the request for reconsideration.

(c) Additional provider records furnished by a provider in conjunction with a provider's request for administrative reconsideration shall have been contemporaneously created.

(d) If there is a failure to meet the timelines specified in this section, no adverse decision based on the noncompliant audit shall be enforced against the provider unless the department shows good cause for the failure to meet the timelines.

**History.** Acts 2013, No. 562, § 7.

**20-77-1718. Termination — Appeals.**

(a) A Medicaid provider that is aggrieved by an adverse decision of the Department of Human Services with respect to termination of the provider's certification or Medicaid provider agreement or an action by

the department that has the same effect as terminating the provider’s certification or Medicaid provider agreement for more than fifteen (15) days may appeal the decision to Pulaski County Circuit Court or in a circuit court in a county in which the provider resides or does business, regardless of whether all administrative remedies have been exhausted.

(b) Pending a determination by the circuit court of the matter on appeal, the provider is entitled to an injunction preserving the provider’s Medicaid participation upon showing that immediate and irreparable injury, loss, or damage to the provider will result, unless the circuit court determines that preserving the provider’s participation is likely to pose a danger to the health or safety of beneficiaries.

(c) This section does not apply to an adverse decision resulting from the department’s determination that there is a credible allegation of fraud for which an investigation is pending.

**History.** Acts 2013, No. 562, § 7.

**SUBCHAPTER 18 — ARKANSAS LONG-TERM CARE PARTNERSHIP PROGRAM**

SECTION.	SECTION.
20-77-1801. Findings.	20-77-1804. Applicability.
20-77-1802. Definitions.	20-77-1805. Continuity of asset protection.
20-77-1803. Arkansas Long-Term Care Partnership Program — Created.	

**20-77-1801. Findings.**

The General Assembly finds that in order to alleviate the financial burden on the state’s Medicaid program, the state must encourage better access to and utilization of affordable long-term care insurance that will pay for some or all of the cost of long-term care services.

**History.** Acts 2007, No. 99, § 1.

**20-77-1802. Definitions.**

As used in this subchapter:

- (1) “Long-term care facility” means a facility required to be licensed under § 20-10-224;
- (2) “Long-term care insurance” means the same as in § 23-97-304; and
- (3) “Long-term care services” means the following necessary services that originate in a setting other than an acute care hospital and that are provided to individuals whose functional capacities are chronically impaired:
  - (A) Physician’s services;
  - (B) Nursing services;
  - (C) Diagnostic services;



- (D) Therapeutic services including physical therapy, speech therapy, and occupational therapy;
- (E) Rehabilitative services;
- (F) Maintenance services;
- (G) Personal care services individually designed to assist with an individual's physical dependency needs related to bathing, bladder and bowel requirements, dressing, eating, personal hygiene, medications, mobility, incidental housekeeping, laundry, and shopping for personal maintenance items;
- (H) Transportation services;
- (I) Day care services;
- (J) Respite care services; and
- (K) Services provided by chiropractors, podiatrists, and optometrists.

**History.** Acts 2007, No. 99, § 1.

### **20-77-1803. Arkansas Long-Term Care Partnership Program — Created.**

(a) The Arkansas Long-Term Care Partnership Program is created within the Department of Human Services.

(b) The Department of Human Services in cooperation with the Insurance Commissioner shall submit applications to the United States Department of Health and Human Services necessary to obtain approval to:

(1) Establish a process for precertification of long-term care insurance policies that meets all the requirements of the program;

(2) Establish minimum requirements that long-term care insurance policies shall meet in order to qualify for precertification, including without limitation:

(A) A conspicuous provision alerting consumers to the availability of consumer information and public education provided by the Department of Human Services;

(B) A guarantee that each insured has an option to cover home and community-based services in addition to nursing facility care;

(C) Inflation protection;

(D) Periodic reporting to include explanations of benefits and a record of insurance payments that count toward Medicaid resource exclusion; and

(E) Reports to the program as the Department of Human Services may require;

(3) Include provisions for reciprocal agreements with other states to extend the Medicaid eligibility protections in subdivision (b)(4) of this section to purchasers of long-term care policies in those states, if at the time the long-term care policies were issued, the policies qualified for precertification in this state;

(4) Include provisions that Medicaid eligibility determinations in the long-term care or related waiver categories for individuals who are the

beneficiaries of precertified long-term care insurance policies shall include a resource disregard of one dollar (\$1.00) for every dollar of long-term care insurance benefits paid under the individual's prequalified long-term care insurance policy for long-term care services; and

(5) Include an outreach program to educate consumers about the need for long-term care, the availability of long-term care insurance, and the asset protections available under this subsection.

**History.** Acts 2007, No. 99, § 1.

**20-77-1804. Applicability.**

This subchapter does not supersede the obligations under the Long-Term Care Insurance Act of 2005, § 23-97-301 et seq.

**History.** Acts 2007, No. 99, § 1.

**20-77-1805. Continuity of asset protection.**

If this subchapter is repealed, any Medicaid asset protection afforded under § 20-77-1803 shall remain effective for the life of the individual receiving long-term care services under this subchapter.

**History.** Acts 2007, No. 99, § 1.

**SUBCHAPTER 19 — ASSESSMENT FEE ON HOSPITALS TO IMPROVE HEALTH CARE ACCESS**

SECTION.

- 20-77-1901. Definitions.
- 20-77-1902. Assessment.
- 20-77-1903. Program administration.
- 20-77-1904. Hospital Assessment Account.
- 20-77-1905. Exemptions.
- 20-77-1906. Quarterly notice and collection.

SECTION.

- 20-77-1907. Notice of assessment.
- 20-77-1908. Medicaid hospital access payments.
- 20-77-1909. Effectiveness and cessation.
- 20-77-1910. State plan amendment.

**Effective Dates.** Acts 2009, No. 562, § 2: Mar. 24, 2009. Emergency clause provided: "It is found and determined by the General Assembly of the State of Arkansas that hospitals are struggling to remain viable in providing access to health care services and the payments created in this act will allow hospitals to provide access to quality health care for the citizens of Arkansas. Therefore, an emergency is declared to exist and this act

being immediately necessary for the preservation of the public peace, health, and safety shall become effective on: (1) The date of its approval by the Governor; (2) If the bill is neither approved nor vetoed by the Governor, the expiration of the period of time during which the Governor may veto the bill; or (3) If the bill is vetoed by the Governor and the veto is overridden, the date the last house overrides the veto."



**20-77-1901. Definitions.**

As used in this subchapter:

(1) "Division" means the Division of Medical Services of the Department of Human Services;

(2) "Hospital" means a health care facility licensed as a hospital by the Division of Health Facilities Services under § 20-9-213;

(3) "Medicare Cost Report" means CMS-2552-96, the Cost Report for Electronic Filing of Hospitals, as it existed on January 1, 2009;

(4) "Net patient revenue" means the amount calculated in accordance with generally accepted accounting principles for hospitals that is reported on Worksheet G-3, Column 1, Line 3, of the Medicare Cost Report adjusted to exclude nonhospital revenue;

(5)(A) "Nonstate government-owned hospital" means a hospital that is owned and operated by an agency or a unit of a county or municipal government, including without limitation a hospital owned and operated by:

(i) A county under § 14-263-101 et seq.; or

(ii) A city under § 14-264-101 et seq.

(B) "Nonstate government-owned hospital" does not include a hospital that is owned by an agency or unit of county or municipal government but is contracted or leased to an individual, firm, or corporation that is not a government entity;

(6) "Privately operated hospital" means a licensed hospital in Arkansas other than:

(A) Any hospital that is owned and operated by the federal government;

(B) Any hospital that is an agency or a unit of state government, including without limitation a hospital owned by a state agency or a state university; and

(C) Any nonstate government-owned hospital;

(7) "Specialty hospital" means an acute care general hospital that:

(A) Limits services primarily to children and qualifies as exempt from the Medicare prospective payment system regulation; or

(B) Is primarily or exclusively engaged in the care and treatment of patients with cardiac conditions;

(8) "State plan amendment" means a change or update to the state Medicaid plan;

(9) "Upper payment limit" means the maximum ceiling imposed by federal regulation on privately owned hospital Medicaid reimbursement for inpatient services under 42 C.F.R. § 447.272 and outpatient services under 42 C.F.R. § 447.321; and

(10)(A) "Upper payment limit gap" means the difference between the upper payment limit and Medicaid payments not financed using hospital assessments made to all privately operated hospitals.

(B) The upper payment limit gap shall be calculated separately for hospital inpatient and outpatient services.

(C) Medicaid disproportionate share payments shall be excluded from the calculation of the upper payment limit gap.

**History.** Acts 2009, No. 562, § 1.

### **20-77-1902. Assessment.**

(a)(1) An assessment is imposed on each hospital except those exempted under § 20-77-1905 for each state fiscal year in an amount calculated as a percentage of each hospital's net patient revenue.

(2) The assessment rate shall be determined annually based upon the percentage of net patient revenue needed to generate an amount up to the nonfederal portion of the upper payment limit gap plus the annual fee to be paid to Medicaid under § 20-77-1904(f)(1)(C), but in no case at a rate that would cause the assessment proceeds to exceed the indirect guarantee threshold set forth in 42 CFR § 433.68(f)(3)(i).

(b)(1)(A) Except as set forth in subdivision (b)(1)(B) or (b)(1)(C), for state fiscal year 2010, net patient revenue shall be determined using the data from each hospital's fiscal year 2007 Medicare Cost Report contained in the Centers for Medicare & Medicaid Services' Healthcare Cost Report Information System file dated June 30, 2008.

(B) If a hospital's fiscal year 2007 Medicare Cost Report is not contained in the Centers for Medicare & Medicaid Services' Healthcare Cost Report Information System file dated June 30, 2008, the hospital shall submit a copy of the hospital's 2007 Medicare Cost Report to the Division of Medical Services of the Department of Human Services in order to allow the division to determine the hospital's net patient revenue for state fiscal year 2010.

(C) If a hospital commenced operations after the due date for a 2007 Medicare Cost Report, the hospital shall submit its 2008 Medicare Cost Report to the division in order to allow the division to determine the hospital's net patient revenue for state fiscal year 2010.

(2) For each subsequent state fiscal year, net patient revenue shall be calculated using the data from each hospital's most recent audited Medicare Cost Report available at the time of the calculation.

(c) This subchapter does not authorize a unit of county or local government to license for revenue or impose a tax or assessment upon hospitals or a tax or assessment measured by the income or earnings of a hospital.

**History.** Acts 2009, No. 562, § 1; 2011, No. 19, § 1.

**Amendments.** The 2011 amendment substituted "at a rate that would cause the assessment proceeds to exceed the

indirect guarantee threshold set forth in 42 CFR § 433.68(f)(3)(i)" for "greater than one percent (1%) of net patient revenue" in (a)(2).

### **20-77-1903. Program administration.**

(a) The Director of the Division of Medical Services of the Department of Human Services shall administer the assessment program created in this subchapter.



(b)(1) The Division of Medical Services of the Department of Human Services shall adopt rules to implement this subchapter.

(2) Unless otherwise provided in this subchapter, the rules adopted under subdivision (b)(1) of this section shall not grant any exceptions to or exemptions from the hospital assessment imposed under § 20-77-1902.

(3) The rules adopted under subdivision (b)(1) of this section shall include any necessary forms for:

(A) Proper imposition and collection of the assessment imposed under § 20-77-1902;

(B) Enforcement of this subchapter, including without limitation letters of caution or sanctions; and

(C) Reporting of net patient revenue.

(c) To the extent practicable, the division shall administer and enforce this subchapter and collect the assessments, interest, and penalty assessments imposed under this subchapter using procedures generally employed in the administration of the division's other powers, duties, and functions.

**History.** Acts 2009, No. 562, § 1; 2011, No. 19, § 2. inserted "any necessary" in the introductory language of (b)(3).

**Amendments.** The 2011 amendment

## **20-77-1904. Hospital Assessment Account.**

(a)(1) There is created within the Arkansas Medicaid Program Trust Fund, § 19-5-985, a designated account known as the Hospital Assessment Account.

(2) The hospital assessments imposed under § 20-77-1902 shall be deposited into the Hospital Assessment Account.

(b) Moneys in the Hospital Assessment Account shall consist of:

(1) All moneys collected or received by the Division of Medical Services of the Department of Human Services from hospital assessments imposed under § 20-77-1902;

(2) Any interest or penalties levied in conjunction with the administration of this subchapter; and

(3) Any appropriations, transfers, donations, gifts, or moneys from other sources, as applicable.

(c) The Hospital Assessment Account shall be separate and distinct from the general fund and shall be supplementary to the Arkansas Medicaid Program Trust Fund.

(d) Moneys in the Hospital Assessment Account shall not be used to replace other general revenues appropriated and funded by the General Assembly or other revenues used to support Medicaid.

(e) The Hospital Assessment Account shall be exempt from budgetary cuts, reductions, or eliminations caused by a deficiency of general revenues.

(f)(1) Except as necessary to reimburse any funds borrowed to supplement funds in the Hospital Assessment Account, the moneys in the Hospital Assessment Account shall be used only as follows:

(A) To make inpatient and outpatient hospital access payments under § 20-77-1908;

(B) To reimburse moneys collected by the division from hospitals through error or mistake or under this subchapter; or

(C) To pay an annual fee to the division in the amount of three and three-quarters percent (3.75%) of the assessments collected from hospitals under § 20-77-1902 each state fiscal year.

(2)(A) The Hospital Assessment Account shall retain account balances remaining each fiscal year.

(B) At the end of each fiscal year, any positive balance remaining in the Hospital Assessment Account shall be factored into the calculation of the new assessment rate by reducing the amount of hospital assessment funds that must be generated during the subsequent fiscal year.

(3) A hospital shall not be guaranteed that its inpatient and outpatient hospital access payments will equal or exceed the amount of its hospital assessment.

**History.** Acts 2009, No. 562, § 1.

**Cross References.** Arkansas Medicaid Program Trust Fund, § 19-5-985.

### **20-77-1905. Exemptions.**

(a) The following hospitals shall be exempt from the assessment imposed under § 20-77-1902 unless the exemption is adjudged to be unconstitutional or otherwise determined to be invalid:

(1) Hospitals that are not privately operated hospitals;

(2) Hospitals licensed by the Department of Health as rehabilitation hospitals; and

(3) Specialty hospitals.

(b) If an exemption under subdivision (a) of this section is adjudged to be unconstitutional or otherwise determined to be invalid, the applicable hospitals shall pay the assessment imposed under § 20-77-1902.

**History.** Acts 2009, No. 562, § 1.

### **20-77-1906. Quarterly notice and collection.**

(a)(1) The annual assessment imposed under § 20-77-1902 shall be due and payable on a quarterly basis.

(2) However, an installment payment of an assessment imposed by § 20-77-1902 shall not be due and payable until:

(A) The Division of Medical Services of the Department of Human Services issues the written notice required by § 20-77-1907(a) stating that the payment methodologies to hospitals required under § 20-77-1908 have been approved by the Centers for Medicare & Medicaid Services and the waiver under 42 C.F.R. § 433.68 for the



assessment imposed by § 20-77-1902, if necessary, has been granted by the Centers for Medicare & Medicaid Services;

(B) The thirty-day verification period required by § 20-77-1907(b) has expired; and

(C) The division has made all quarterly installments of inpatient and outpatient hospital access payments that were otherwise due under § 20-77-1908 consistent with the effective date of the approved state plan amendment and waiver.

(3) After the initial installment has been paid under this section, each subsequent quarterly installment payment of an assessment imposed by § 20-77-1902 shall be due and payable within ten (10) business days after the hospital has received its inpatient and outpatient hospital access payments due under § 20-77-1908 for the applicable quarter.

(b) The payment by the hospital of the assessment created in this subchapter shall be reported as an allowable cost for Medicaid reimbursement purposes.

(c)(1) If a hospital fails to timely pay the full amount of a quarterly assessment, the division shall add to the assessment:

(A) A penalty assessment equal to five percent (5%) of the quarterly amount not paid on or before the due date; and

(B) On the last day of each quarter after the due date until the assessed amount and the penalty imposed under subdivision (c)(1)(A) of this section are paid in full, an additional five percent (5%) penalty assessment on any unpaid quarterly and unpaid penalty assessment amounts.

(2) Payments shall be credited first to unpaid quarterly amounts, rather than to penalty or interest amounts, beginning with the most delinquent installment.

(3) If the division is unable to recoup from Medicaid payments the full amount of any unpaid assessment or penalty assessment, or both, the division may file suit in a court of competent jurisdiction to collect up to double the amount due, the division's costs related to the suit and reasonable attorney's fees.

**History.** Acts 2009, No. 562, § 1; 2011, No. 19, § 3.

**Amendments.** The 2011 amendment added (c)(3).

## **20-77-1907. Notice of assessment.**

(a)(1) The Division of Medical Services of the Department of Human Services shall send a notice of assessment to each hospital informing the hospital of the assessment rate, the hospital's net patient revenue calculation, and the estimated assessment amount owed by the hospital for the applicable fiscal year.

(2) Except as set forth in subdivision (a)(3) of this section, annual notices of assessment shall be sent at least forty-five (45) days before the due date for the first quarterly assessment payment of each fiscal year.

(3) The first notice of assessment shall be sent within forty-five (45) days after receipt by the division of notification from the Centers for Medicare & Medicaid Services that the payments required under § 20-77-1908 and, if necessary, the waiver granted under 42 C.F.R. § 433.68 have been approved.

(b) The hospital shall have thirty (30) days from the date of its receipt of a notice of assessment to review and verify the assessment rate, the hospital's net patient revenue calculation, and the estimated assessment amount.

(c)(1) If a hospital provider operates, conducts, or maintains more than one (1) hospital in the state, the hospital provider shall pay the assessment for each hospital separately.

(2) However, if the hospital provider operates more than one (1) hospital under one (1) Medicaid provider number, the hospital provider may pay the assessment for the hospitals in the aggregate.

(d)(1) For a hospital subject to the assessment imposed under § 20-77-1902 that ceases to conduct hospital operations or maintain its state license or did not conduct hospital operations throughout a state fiscal year, the assessment for the state fiscal year in which the cessation occurs shall be adjusted by multiplying the annual assessment computed under § 20-77-1902 by a fraction, the numerator of which is the number of days during the year that the hospital operated and the denominator of which is three hundred sixty-five (365).

(2)(A) Immediately upon ceasing to operate, the hospital shall pay the adjusted assessment for that state fiscal year to the extent not previously paid.

(B) The hospital also shall receive payments under § 20-77-1908 for the state fiscal year in which the cessation occurs, which shall be adjusted by the same fraction as its annual assessment.

(e) A hospital subject to an assessment under this subchapter that has not been previously licensed as a hospital in Arkansas and that commences hospital operations during a state fiscal year shall pay the required assessment computed under § 20-77-1902 and shall be eligible for hospital access payments under § 20-77-1908 on the date specified in rules promulgated by the division under the Arkansas Administrative Procedure Act, § 25-15-201 et seq.

(f) A hospital that is exempted from payment of the assessment under § 20-77-1905 at the beginning of a state fiscal year but during the state fiscal year experiences a change in status so that it becomes subject to the assessment shall pay the required assessment computed under § 20-77-1902 and shall be eligible for hospital access payments under § 20-77-1908 on the date specified in rules promulgated by the division under the Arkansas Administrative Procedure Act, § 25-15-201 et seq.

(g) A hospital that is subject to payment of the assessment computed under § 20-77-1902 at the beginning of a state fiscal year but during the state fiscal year experiences a change in status so that it becomes exempted from payment under § 20-77-1905 shall be relieved of its



obligation to pay the hospital assessment and shall become ineligible for hospital access payments under § 20-77-1908 on the date specified in rules promulgated by the division under the Arkansas Administrative Procedure Act, § 25-15-201 et seq.

**History.** Acts 2009, No. 562, § 1.

### **20-77-1908. Medicaid hospital access payments.**

(a) To preserve and improve access to hospital services, for hospital inpatient and outpatient services rendered on or after July 1, 2009, the Division of Medical Services of the Department of Human Services shall make hospital access payments as set forth in this section.

(b) The division shall calculate the hospital access payment amount up to but not to exceed the upper payment limit gap for inpatient and outpatient services.

(c)(1) All hospitals shall be eligible for inpatient and outpatient hospital access payments each state fiscal year as set forth in this subsection other than hospitals described in § 20-77-1905.

(2)(A) A portion of the hospital access payment amount, not to exceed the upper payment limit gap for inpatient services, shall be designated as the inpatient hospital access payment pool.

(B) In addition to any other funds paid to hospitals for inpatient hospital services to Medicaid patients, each eligible hospital shall receive inpatient hospital access payments each state fiscal year equal to the hospital's pro rata share of the inpatient hospital access payment pool based upon the hospital's Medicaid discharges for the most recent audited fiscal period divided by the total number of Medicaid discharges of all eligible hospitals.

(C) Inpatient hospital access payments shall be made on a quarterly basis.

(3)(A) A portion of the hospital access payment amount, not to exceed the upper payment limit gap for outpatient services, shall be designated as the outpatient hospital access payment pool.

(B)(i) In addition to any other funds paid to hospitals for outpatient hospital services to Medicaid patients, each eligible hospital shall receive outpatient hospital access payments each state fiscal year equal to a percentage adjustment determined by dividing the outpatient hospital access payment pool by Medicaid payments for outpatient services paid to all eligible hospitals.

(ii) The percentage adjustment shall be multiplied by the Medicaid payments for outpatient services paid to the eligible hospital in order to determine the amount of each eligible hospital's outpatient hospital access payment.

(C) Outpatient hospital access payments shall be made on a quarterly basis.

(d) A hospital access payment shall not be used to offset any other payment by Medicaid for hospital inpatient or outpatient services to Medicaid beneficiaries, including without limitation any fee-for-service,

per diem, private hospital inpatient adjustment, or cost-settlement payment.

**History.** Acts 2009, No. 562, § 1; 2011, No. 1121, § 14. redesignated the introductory language of (c) as (c)(1) and redesignated the remaining subdivisions accordingly.

**Amendments.** The 2011 amendment

### 20-77-1909. Effectiveness and cessation.

(a) The assessment imposed under § 20-77-1902 shall cease to be imposed, the Medicaid hospital access payments made under § 20-77-1908 shall cease to be paid, and any moneys remaining in the Hospital Assessment Account in the Arkansas Medicaid Program Trust Fund shall be refunded to hospitals in proportion to the amounts paid by them if:

(1) The inpatient or outpatient hospital access payments required under § 20-77-1908 are changed or the assessments imposed under § 20-77-1902 are not eligible for federal matching funds under Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq., or Title XXI of the Social Security Act, 42 U.S.C. § 1397aa et seq.; or

(2) It is determined in the course of an administrative adjudication or in an action under § 25-15-207 that the Division of Medical Services of the Department of Human Services:

(A) Established Medicaid hospital payment rates that include an offset, in whole or in part, for any hospital access payments under § 20-77-1908; or

(B) Included the net effect of any hospital access payment under § 20-77-1908 when considering whether Medicaid hospital payment rates are:

(i) Consistent with efficiency, economy, and quality of care; and

(ii) Sufficient to enlist enough providers so that Medicaid care and services are available at least to the extent that the care and services are available to the general population in the geographic area.

(b)(1) The assessment imposed under § 20-77-1902 shall cease to be imposed and the Medicaid hospital access payments under § 20-77-1908 shall cease to be paid if the assessment is determined to be an impermissible tax under Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq.

(2) Moneys in the Hospital Assessment Account in the Arkansas Medicaid Program Trust Fund derived from assessments imposed before the determination described in subdivision (b)(1) of this section shall be disbursed under § 20-77-1908 to the extent federal matching is not reduced due to the impermissibility of the assessments, and any remaining moneys shall be refunded to hospitals in proportion to the amounts paid by them.

**History.** Acts 2009, No. 562, § 1; 2011, No. 19, § 4. Medicaid hospital access payments made under § 20-77-1908 shall cease to be paid”

**Amendments.** The 2011 amendment substituted “shall cease to be imposed, the for “shall not take effect or shall cease to be imposed” in the introductory language



of (a); deleted former (a)(1) and (2) and redesignated (a)(3) as present (a)(1); added present (a)(2); and substituted “shall cease to be imposed and the Medic-

aid hospital access payments under § 20-77-1908 shall cease to be paid” for “shall not take effect or shall cease to be imposed” in (b)(1).

### **20-77-1910. State plan amendment.**

(a) The Division of Medical Services of the Department of Human Services shall file with the Centers for Medicare & Medicaid Services a state plan amendment to implement the requirements of this subchapter, including the payment of hospital access payments under § 20-77-1908, no later than forty-five (45) days after March 24, 2009.

(b) If the state plan amendment is not approved by the Centers for Medicare & Medicaid Services, the division shall:

- (1) Not implement the assessment imposed under § 20-77-1902; and
- (2) Return any assessment fees to the hospitals that paid the fees if assessment fees have been collected.

**History.** Acts 2009, No. 562, § 1.

## **SUBCHAPTER 20 — ARKIDS FIRST MEDICAL ASSISTANCE PROGRAMS ENROLLMENT AND RETENTION IMPROVEMENT PROGRAM**

### **SECTION.**

20-77-2001. Findings.

20-77-2002. Administration.

### **SECTION.**

20-77-2003. ARKids First enrollment and renewals.

**A.C.R.C. Notes.** Acts 2011, No. 771, § 2, provided: “This subchapter shall be implemented only if and to the extent that the Department of Human Services can obtain the necessary waiver approval

from the Centers for Medicare and Medicaid Services and that the required state general revenue to support these initiatives is made available.”

### **20-77-2001. Findings.**

The General Assembly finds that:

(1) Almost two-thirds ( $\frac{2}{3}$ ) of the state’s uninsured children are already eligible for either ARKids First A or B, but many are not enrolled or do not remain enrolled;

(2) Twenty thousand (20,000) children annually are dropped from the ARKids First A or B programs because of procedural requirements, not through a change in eligibility;

(3) The Child Health Insurance Program Reauthorization Act of 2009, Pub. L. No. 111-3, offers financial incentives to states that adopt measures to streamline enrollment and reenrollment in their Medicaid programs;

(4) Other states have found that simplifying enrollment and reenrollment for families can also save the state administrative costs

through improved use of technology and more efficient use of databases and resources already available to the state; and

(5) Working to enroll all eligible children can help to inform planning efforts to effectively enroll newly eligible adults in Medicaid or private insurance as the state implements the Patient Protection and Affordable Care Act, Pub. L. No. 111-148.

**History.** Acts 2011, No. 771, § 1; 2013, No. 1132, § 52. in (5), inserted "Patient Protection and" and "Pub. L. No. 111-148."

**Amendments.** The 2013 amendment,

## **20-77-2002. Administration.**

(a) In administering the ARKids First A and B programs, the Department of Human Services shall:

(1) Work to increase enrollment among eligible uninsured children under nineteen (19) years of age;

(2) Work to improve retention of coverage among eligible uninsured children under nineteen (19) years of age;

(3) Design the application and annual renewal processes to minimize administrative barriers for applicants and enrolled children under nineteen (19) years of age to minimize gaps in coverage for children who are eligible and to reduce state administrative costs;

(4) Modify eligibility renewal procedures to improve retention and increase the number of children who retain coverage; and

(5)(A) Manage outreach, application, and renewal procedures with the goal of achieving annual improvements in enrollment, enrollment rates, renewals, and renewal rates.

(B) To make the improvements required under subdivision (a)(1) of this section, the department shall maximize the use of existing program databases to obtain information related to earned and unearned income for purposes of eligibility determination and renewals, including without limitation:

(i) The Supplemental Nutrition Assistance Program;

(ii) The state child care subsidy program;

(iii) The Arkansas Better Chance Program;

(iv) The National School Lunch Program;

(v) Federal Social Security Administration programs; and

(vi) The Department of Workforce Services database.

(b) To simplify and streamline the renewal process, the department shall:

(1) Maximize the use of data matches, online submissions, and telephone interviews; and

(2) Develop a pre-populated renewal form that will be sent to families to complete and return for use in cases in which the department is unable to renew coverage through the use of data matching, online submissions, or telephone interviews.



**History.** Acts 2011, No. 771, § 1.                      § 20-77-2002(5)(B)(2) shall be developed  
**A.C.R.C. Notes.** Acts 2011, No. 771,              and tested on or before December 31,  
 § 3, provided: “The form required under              2011.”

**20-77-2003. ARKids First enrollment and renewals.**

- (a) The Department of Human Services shall perform the initiatives under subsection (b) of this section to increase ARKids First enrollment and renewals and position the state to compete for a performance bonus payment under the federal Children’s Health Insurance Program Reauthorization Act of 2009, Pub. L. No. 111-3.
- (b) The department shall make best efforts to obtain approval from the Centers for Medicare & Medicaid Services for the following:
  - (1) For each child enrolled in ARKids First A who becomes ineligible to complete his or her ARKids First A enrollment period for financial reasons, establishing a process to allow ARKids First B coverage from the date of ineligibility through the end date of the ARKids First A enrollment period;
  - (2) An ex-parte renewal process for ARKids First A and ARKids First B, in which the state performs the eligibility redetermination to the maximum extent possible based on information contained in the ARKids First file or by obtaining other information available to the state through other sources, such as income databases, before it seeks any information from the child’s parent or representative; and
  - (3) An Express Lane Eligibility enrollment option that allows use of other public program databases and findings to reach and enroll children in the ARKids First A and ARKids First B programs.

**History.** Acts 2011, No. 771, § 1.

**SUBCHAPTER 21 — MEDICAID ELIGIBILITY VERIFICATION SYSTEM**

SECTION.	SECTION.
20-77-2101. Definitions.	20-77-2103. Medicaid Eligibility Verifica-
20-77-2102. Medicaid Eligibility Verifica-	tion System — Require-
tion System.	ments.

**20-77-2101. Definitions.**

- (1) “Arkansas Data Services Hub” means the Arkansas data services hub that provides an electronic method to verify:
  - (A) Age, residency, and child support information via the Department of Finance and Administration;
  - (B) Age, marriage, and death information via the Division of Vital Records of the Department of Health;
  - (C) Age, social security number, citizenship, and Medicare coverage information via the state online portal to the Social Security Administration;
  - (D) Employment earnings and unemployment benefit payment information via the Department of Workforce Services; and
  - (E) Receipt of Supplemental Nutrition Assistance Program benefits;

(2) “Federal Data Services Hub” means the federal data services hub that provides an electronic method to verify:

(A) Social Security number verification via the Social Security Administration;

(B) Citizenship verification via the Social Security Administration;

(C) Incarceration verification via the Social Security Administration;

(D) Verification of income under Title II of the Social Security Act, 42 U.S.C. § 401 et seq., via the Social Security Administration;

(E) Quarters of coverage information via the Social Security Administration;

(F) Modified adjusted gross income information via the Internal Revenue Service;

(G) Immigration status verification via the Department of Homeland Security;

(H) Indicators for lawful presence, qualified noncitizen, and five-year bar status via the Department of Homeland Security; and

(I) Public minimum essential coverage;

(3)(A) “Medicaid eligible” means an individual who is eligible for Medicaid benefits.

(B) “Medicaid eligible” does not include establishment of an entitlement to a particular benefit package or the reimbursement of particular medical assistance; and

(4) “Supplemental manual verification investigation” means an investigation conducted by the Department of Human Services or its designee to gather information by methods such as contacting family members, employers, and medical facilities to verify information received via the Medicaid Eligibility Verification System.

**History.** Acts 2013, No. 1265, § 1.

### **20-77-2102. Medicaid Eligibility Verification System.**

The Department of Human Services shall establish and maintain the Medicaid Eligibility Verification System that is designed to prevent fraud in the establishment and maintenance of Medicaid eligibility.

**History.** Acts 2013, No. 1265, § 1.

### **20-77-2103. Medicaid Eligibility Verification System — Requirements.**

(a) Beginning concurrently with the establishment of live, full-time operation of the Federal Data Services Hub and the Arkansas Data Services Hub, the Department of Human Services shall deploy an automated eligibility verification system that electronically queries the Federal Data Services Hub and the Arkansas Data Services Hub under this subchapter.

(b) The department shall electronically query the Federal Data Services Hub upon receiving a Medicaid application and to the extent



permitted by the Federal Data Services Hub for purposes of Medicaid eligibility renewal.

(c) If the Medicaid eligibility or continued Medicaid eligibility of an individual can be determined based on information received via the Federal Data Services Hub, the department shall determine eligibility and notify the applicant or recipient.

(d) If the Medicaid eligibility or continued eligibility of an individual cannot be determined based on information received via the Federal Data Services Hub, the department shall electronically query the Arkansas Data Services Hub and determine whether the information received from each data services hub is:

(1) Reasonably compatible and establishes that the individual is Medicaid eligible;

(2) Reasonably compatible and establishes that the individual is not Medicaid eligible; or

(3) Not reasonably compatible.

(e) If the information received from the Federal Data Services Hub and the Arkansas Data Services Hub is reasonably compatible, the department shall enter an eligibility determination and inform the applicant or recipient of the decision.

(f)(1) If the information received from the Federal Data Services Hub and Arkansas Data Services Hub is not reasonably compatible, the department shall conduct a supplemental manual verification investigation.

(2) At the conclusion of the supplemental manual verification investigation, the department shall enter an eligibility determination and inform the applicant or recipient of the decision.

(g) The department may adopt rules to implement this subchapter.

**History.** Acts 2013, No. 1265, § 1.

**SUBCHAPTER 22 — HEALTHCARE QUALITY AND PAYMENT POLICY ADVISORY COMMITTEE**

SECTION.

20-77-2201. Title.

20-77-2202. Definitions.

20-77-2203. Healthcare Quality and Payment Policy Advisory Committee — Created — Membership.

20-77-2204. Purpose.

20-77-2205. Medicaid payment and reimbursement rules related to

SECTION.

the development of episodes of care.

20-77-2206. Powers and duties of the Healthcare Quality and Payment Policy Advisory Committee.

20-77-2207. Confidentiality.

**20-77-2201. Title.**

This subchapter shall be known and may be cited as the “Healthcare Quality and Payment Policy Advisory Committee Act”.

**History.** Acts 2013, No. 1266, § 1.

**20-77-2202. Definitions.**

As used in this subchapter:

(1) “Data, records, reports, and documents” means a recording of an interview and an oral or written proceeding, report, statement, minute, memorandum, data, and other documentation collected or compiled to establish or modify episodes of care, quality measures, or target prices; and

(2) “Healthcare provider” means one (1) of the following individuals or entities licensed by the State of Arkansas to provide healthcare services:

- (A) An advanced practice nurse;
- (B) An athletic trainer;
- (C) An audiologist;
- (D) A certified orthotist;
- (E) A chiropractor;
- (F) A community mental health center or clinic;
- (G) A dentist;
- (H) A home health care provider;
- (I) A hospice care provider;
- (J) A hospital-based service;
- (K) A hospital;
- (L) A licensed ambulatory surgery center;
- (M) A licensed certified social worker;
- (N) A licensed dietician;
- (O) A licensed durable medical equipment provider;
- (P) A licensed professional counselor;
- (Q) A licensed psychological examiner;
- (R) A long-term care facility;
- (S) An occupational therapist;
- (T) An optometrist;
- (U) A pharmacist;
- (V) A physical therapist;
- (W) A physician or surgeon;
- (X) A podiatrist;
- (Y) A prosthetist;
- (Z) A psychologist;
- (AA) A respiratory therapist;
- (BB) A rural health clinic;
- (CC) A speech pathologist;

(DD) Another healthcare practitioner as determined by the Department of Human Services in rules adopted under the Arkansas Administrative Procedure Act, § 25-15-201 et seq.; and

(EE) Another person or entity enrolled to provide health or medical care services or goods authorized under the medical assistance programs provided in this state under Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq.



**20-77-2203. Healthcare Quality and Payment Policy Advisory Committee — Created — Membership.**

(a) The Healthcare Quality and Payment Policy Advisory Committee is created.

(b)(1) Except as provided under subdivision (b)(2) of this section, the committee shall consist of the following seven (7) voting members:

(A) Three (3) members appointed by the President Pro Tempore of the Senate, including:

(i) One (1) physician in good standing with the Arkansas State Medical Board;

(ii) One (1) member nominated by the Arkansas Hospital Association who represents hospitals with more than one hundred (100) beds; and

(iii) One (1) medical director of a commercially owned insurance company participating with the Division of Medical Services of the Department of Human Services in the Arkansas Health Care Payment Improvement Initiative;

(B) Three (3) members appointed by the Speaker of the House of Representatives, including:

(i) Two (2) physicians nominated by the Arkansas Medical Society; and

(ii) One (1) member nominated by the Arkansas Hospital Association who represents hospitals with fewer than one hundred (100) beds; and

(C) The Director of the Division of Medical Services of the Department of Human Services.

(2)(A) For purposes of reviewing a draft rule related to long-term care services and supports, the committee shall include the following five (5) additional voting members:

(i) One (1) member nominated by the Arkansas Health Care Association to represent nursing homes and appointed by the President Pro Tempore of the Senate;

(ii) One (1) member nominated by the Arkansas Association of Area Agencies on Aging and appointed by the President Pro Tempore of the Senate;

(iii) One (1) member nominated by the Arkansas Residential Assisted Living Association and appointed by the President Pro Tempore of the Senate;

(iv) One (1) member nominated by the Arkansas Residential Assisted Living Association and appointed by the Speaker of the House of Representatives; and

(v) One (1) member nominated by the HomeCare Association of Arkansas and appointed by the Speaker of the House of Representatives.

(B)(i) As used in subdivision (b)(2)(A) of this section, “long-term care services and supports” does not include services provided in intermediate care facilities for individuals with developmental dis-

abilities or services provided by an entity licensed or certified by the Division of Developmental Disabilities Services of the Department of Human Services.

(ii) For purposes of reviewing a draft rule related to services provided in intermediate care facilities for individuals with developmental disabilities and services provided by an entity licensed or certified by the division, § 20-77-2205(b)(2) applies.

(3) A medical director of a commercially owned insurance company participating with the Division of Medical Services in the Arkansas Health Care Payment Improvement Initiative who is not appointed under subdivision (b)(1)(A)(iii) of this section may serve as an ex officio member of the committee but shall not vote.

(c) The committee may appoint subcommittees of the committee to study, research, and advise the committee.

(d) The Department of Human Services may provide offices and staff for the committee.

(e)(1) The members of the committee shall serve two-year terms.

(2) At the first meeting of the committee, the length of the terms of the initial appointees shall be determined by lot.

(f) The members of the committee shall hold the first meeting in offices made available by the department within thirty (30) days of the appointment of the members of the committee.

(g) The committee annually shall select from its membership a chair and a vice chair.

(h)(1) A majority of the membership of the committee constitutes a quorum.

(2) A majority vote of the members present is required for any action of the committee.

(i)(1) A vacancy on the committee due to death, resignation, removal, or another cause shall be filled in the same manner as the initial appointment.

(2) A member appointed to fill a vacancy shall serve for the remainder of the vacated term.

(j) The members of the committee may be removed by the appointing official for cause.

(k) Members of the committee except those employed by the state may receive expense reimbursement and stipends under § 25-16-902.

**History.** Acts 2013, No. 1266, § 1.

### **20-77-2204. Purpose.**

The purpose of the Healthcare Quality and Payment Policy Advisory Committee is to make recommendations and provide advice and assistance to the Department of Human Services concerning the promulgation of rules submitted by the department to the committee to promote high-quality, safe, effective, timely, efficient, and patient-centered physician services, hospital services, and long-term care services and supports in the State of Arkansas, as related to the development of



episodes of care and the episodes-of-care target prices and quality metrics within the Arkansas Health Care Payment Improvement Initiative.

**History.** Acts 2013, No. 1266, § 1.

**20-77-2205. Medicaid payment and reimbursement rules related to the development of episodes of care.**

(a)(1) The Department of Human Services shall not adopt a rule under the Arkansas Administrative Procedure Act, § 25-15-201 et seq., related to the development of episodes of care for patient-centered physician services, hospital services, and long-term care services and supports, including without limitation the episodes-of-care target prices and quality metrics, without first submitting the proposed rule to the Healthcare Quality and Payment Policy Advisory Committee for review.

(2) Concurrent with a submission of a draft rule to the committee under subdivision (a)(1) of this section, the department shall issue a public notice of the draft rule for which the department shall:

(A) Include in the notice a statement of the terms or substance of the draft rule and the specific provider category or categories affected;

(B) Mail the notice to any person who requests notice of a submission of a draft rule to the committee under subdivision (a)(1) of this section; and

(C) Post the notice on its website in a section dedicated to the committee.

(3) Concurrent with a submission of a draft rule to the committee under subdivision (a)(1) of this section, the department shall post the draft rule on its website in a section dedicated to the committee during the entire period the draft rule is under the consideration of the committee.

(4) The department shall provide to a person who requests the information a meeting notice that identifies the time and place of each committee and subcommittee meeting and the draft rules under the consideration of the committee or subcommittee at each meeting.

(b)(1) At least forty-five (45) days before initiating the promulgation process under the Arkansas Administrative Procedure Act, § 25-15-201 et seq., for a rule related to the development of episodes of care for patient-centered physician services, hospital services, or long-term care services and supports, including without limitation the episodes-of-care target prices and quality metrics, the department shall submit the draft rule to the committee for review and advice.

(2)(A) If the draft rule pertains to a healthcare provider listed in § 20-77-2202(2) whose provider category is not represented on the committee, the committee shall seek representation by designated representatives of the statewide provider association or associations for that provider category for the purpose of review and advice.

(B) The committee shall:

(i) Provide at least twenty-five (25) days for the representatives of the affected healthcare providers to review and comment on the draft rule; and

(ii) Afford the representatives the opportunity to participate in committee and subcommittee deliberations on the draft rule.

(C)(i) The committee shall not provide advice to the department without seeking the input of the affected healthcare providers.

(ii) If the committee does not reach agreement with a provider association on a draft rule pertaining to a healthcare provider not represented on the committee, the committee shall prepare a written report that objectively states the information and viewpoints presented but does not advise the department concerning how to proceed on the draft rule.

(c) A rule required to be submitted to the committee under subsection (b) of this section that is adopted without following this section is void.

(d)(1) The committee shall issue and deliver a written advisory statement to the department within thirty (30) calendar days after the department's submission of the proposed rule to the committee.

(2) If the department fails to follow the advice of the committee with respect to a proposed rule under this section, the department, before beginning the promulgation process, shall prepare a written report setting out the advice of the committee and an explanation of the reason that the department decided not to follow the committee's advice with regard to the rule.

(3) The department shall make available for public review the report required under subdivision (d)(2) of this section and the text of the proposed rule during the public comment period.

(4) The department may begin the promulgation process for the proposed rule if the committee does not issue and deliver a written advisory statement to the department within thirty (30) calendar days after the department's submission of the proposed rule to the committee.

(e) After the public comment period, the department shall retain and make available for public review the report required under subdivision (d)(2) of this section and the text of any final regulation issued.

**History.** Acts 2013, No. 1266, § 1.

## **20-77-2206. Powers and duties of the Healthcare Quality and Payment Policy Advisory Committee.**

The Healthcare Quality and Payment Policy Advisory Committee shall:

(1) Review and provide advice regarding draft rules submitted by the Department of Human Services under § 20-77-2205;

(2) Have the authority to obtain from the department all data and analysis required to fully meet its charge under § 20-77-2204; and



(3) Provide reports to the Legislative Council upon request.

**History.** Acts 2013, No. 1266, § 1.

**20-77-2207. Confidentiality.**

(a) To the extent that the data, records, reports, and documents identify or could be used to identify an individual patient, a healthcare provider, an institution, or a health plan, the data, records, reports, and documents collected or compiled by or on behalf of the Healthcare Quality and Payment Policy Advisory Committee are confidential and are not subject to disclosure under state and federal law.

(b) Data, records, reports, and documents collected or compiled by or on behalf of the Healthcare Quality and Payment Policy Advisory Committee are not admissible in a legal proceeding and are exempt from discovery and disclosure to the same extent that records of and testimony before committees that evaluate the quality of medical or hospital care are exempt under § 16-46-105(a)(1).

(c) A healthcare provider’s use of the information in its internal operations does not operate as a waiver of the confidentiality protections under this section.

(d) The committee shall treat data, records, reports, and documents in a manner consistent with state and federal privacy requirements, including without limitation the privacy requirements under the federal Health Insurance Portability and Accountability Act of 1996, 45 C.F.R. § 164.512(i).

**History.** Acts 2013, No. 1266, § 1.

**SUBCHAPTER 23 — HOME CAREGIVER TRAINING**

SECTION.	SECTION.
20-77-2301. Findings — Intent. [Effective April 1, 2014.]	20-77-2304. Exemptions. [Effective April 1, 2014.]
20-77-2302. Definitions. [Effective April 1, 2014.]	20-77-2305. Rules. [Effective April 1, 2014.]
20-77-2303. Training requirement. [Effective April 1, 2014.]	

**Effective Dates.** Acts 2013, No. 1410, § 2: Apr. 1, 2014. Effective date clause provided: “This act is effective on and after April 1, 2014.”

**20-77-2301. Findings — Intent. [Effective April 1, 2014.]**

(a) The General Assembly finds that:

(1) Although a direct-care worker in the State of Arkansas who serves a Medicaid-reimbursable client must undergo a forty-hour training program, a direct-care worker who serves a client in his or her

home and who is not Medicaid-reimbursable has no training requirement; and

(2) Beginning January 1, 2012, and continuing until January 1, 2027, approximately ten thousand (10,000) persons a day turn sixty-five (65) years of age in the United States.

(b) This subchapter is intended to:

(1) Assure disabled citizens and the constantly expanding population of senior citizens in Arkansas that a direct-care worker is properly trained in core competencies; and

(2) Acknowledge the necessity of proper training for all direct-care workers that, in turn, will contribute to a reduction in per capita healthcare costs for Arkansans.

**History.** Acts 2013, No. 1410, § 1.

### **20-77-2302. Definitions. [Effective April 1, 2014.]**

As used in this subchapter:

(1) “Caregiver services” means services provided to an individual in the State of Arkansas to assist the recipient of the services in the activities of daily living, and the recipient of services is fifty (50) years of age or older at the time the services are provided;

(2) “Compensation” means money or another type of property of value received by a provider of caregiver services in exchange for the services of the provider without regard to the source of payment of the money or other type of property;

(3) “Successful completion” means completion of training in acceptable core competencies in the physical skills under § 20-77-2303; and

(4) “Trained in-home assistant” means an individual who has met the requirements of this subchapter and provides caregiver services.

**History.** Acts 2013, No. 1410, § 1.

### **20-77-2303. Training requirement. [Effective April 1, 2014.]**

(a) A person who applies for employment to provide caregiver services in this state for compensation shall provide documentation to an in-home services agency of successful completion of training as a trained in-home assistant under this subchapter.

(b) A person qualifies as a trained in-home assistant under this subchapter if the person:

(1) Is eighteen (18) years of age or older;

(2) Has not been convicted of a felony that would prevent the person from working in a long-term care facility under § 20-38-101 et seq. unless the conviction has been expunged or pardoned; and

(3) Except as provided under subsection (e) of this section, has successfully completed a caregiver training course addressing the following core competencies approved by the department, including not less than forty (40) hours of training in:

(A) Body functions;



- (B) Body mechanics and safety precautions;
- (C) Communication skills;
- (D) Dementia and Alzheimer's diseases;
- (E) Emergency situations, including recognition of conditions and proper procedures;
- (F) Household safety and fire prevention;
- (G) Infection control and prevention, including maintaining a safe and clean working environment;
- (H) Ethical considerations and state law regarding delegation of nursing tasks to unlicensed personnel;
- (I) Nutrition;
- (J) At least sixteen (16) hours of the forty (40) required hours covering physical skills and competent demonstration of such skills for:
  - (i) Ambulation;
  - (ii) Basic housekeeping procedures, including laundry skills;
  - (iii) Bathing, shampooing, and shaving;
  - (iv) Dressing and undressing;
  - (v) Meal preparation and clean up;
  - (vi) Oral hygiene;
  - (vii) Range of motion;
  - (viii) Toileting; and
  - (ix) Transfer techniques;
- (K) Record keeping and documentation of activities;
- (L) Role of caregiver in a healthcare team; and
- (M) Nail and skin care.

(c) The department may expand or reduce the topics acceptable for the caregiver course, but the number of hours of training shall not be modified.

(d) The training required under this subchapter may be certified by an employer if that employer maintains records regarding:

- (1) The identification of the employee who received training;
- (2) The topic for which the training was conducted; and
- (3) The amount of time spent on training.

(e)(1) A person is exempt from the provisions of subdivision (b)(3) of this section if the person has at least one (1) year of experience working in an institutional setting, including without limitation a:

- (A) Home health agency;
- (B) Hospital;
- (C) Hospice; or
- (D) Long-term care facility.

(2) The experience required under subdivision (e)(1) of this section shall be verified by the person's employer during the experience.

**History.** Acts 2013, No. 1410, § 1.

**20-77-2304. Exemptions. [Effective April 1, 2014.]**

An individual may provide caregiver services without the training required under this subchapter if the person is a:

- (1) Certified Nursing Assistant;
- (2) Licensed practical nurse;
- (3) Parent, grandparent, child, grandchild, or sibling of the recipient of the services;
- (4) Physician;
- (5) Registered nurse;
- (6) Service provider who does not receive compensation for his or her services;
- (7) Licensed social worker;
- (8) Court-appointed legal guardian of the recipient of the caregiver services; or
- (9) A direct-care worker providing caregiver services to a participant in any program licensed, certified, or administered by the Department of Human Services.

**History.** Acts 2013, No. 1410, § 1.

**20-77-2305. Rules. [Effective April 1, 2014.]**

The Department of Health shall adopt rules to implement this subchapter.

**History.** Acts 2013, No. 1410, § 1.

**SUBCHAPTER 24 — HEALTH CARE INDEPENDENCE ACT OF 2013**

SECTION.

- 20-77-2401. Title.  
 20-77-2402. Legislative intent.  
 20-77-2403. Purpose.  
 20-77-2404. Definitions.  
 20-77-2405. Administration of the Health Care Independence Program.

SECTION.

- 20-77-2406. Standards of healthcare coverage through the Health Insurance Marketplace.  
 20-77-2407. Enrollment.  
 20-77-2408. Effective date.

**A.C.R.C. Notes.** Pursuant to § 1-2-207(a), and Section 4 of identical Acts 2013, Nos. 1497 and 1498, this subchapter is set out as enacted by Acts 2013, No. 1498, § 1.

Acts 2013, No. 1497, § 3, and Acts 2013, No. 1498, § 3 provided:

“(a) The implementation of this act is suspended until an appropriation for the implementation of this act is passed by a three-fourths vote of both houses of the Eighty-Ninth General Assembly.

“(b) If an appropriation for the imple-

mentation of this act is not passed by the Eighty-Ninth General Assembly, this act is void.”

Acts 2013, No. 1497, § 4, and Acts 2013, No. 1498, § 4 provided: “The enactment and adoption of this act shall supersede Section 21 of HB1219 of the Eighty-Ninth General Assembly, if Section 21 of HB1219 of the Eighty-Ninth General Assembly is enacted and adopted.”

Acts 2013, Nos. 1497 and 1498, provided:

“WHEREAS, Arkansas has historically



addressed state-specific needs to achieve personal responsibility and affordable health care for its citizens such as the ARHealthNetworks partnership between the state and small businesses; and

"WHEREAS, Arkansas has initiated nationally recognized and transformative changes in the healthcare delivery system through alignment of payment incentives, health care delivery system improvements, enhanced rural health care access, initiatives to reduce waste, fraud and abuse, policies and plan structures to encourage the proper utilization of the healthcare system, and policies to advance disease prevention and health promotion; and

"WHEREAS, Arkansas is uniquely situated to serve as a laboratory of comprehensive and innovative healthcare reform that can reduce the state and federal obligations to entitlement spending; and

"WHEREAS, faced with the disruptive challenges from federal legislation and regulations, the General Assembly asserts its responsibility for local control and innovation to achieve health care access, improved health care quality, reduce traditional Medicaid enrollment, remove disincentives for work and social mobility, and required cost-containment; and

"WHEREAS, the General Assembly hereby creates the Health Care Independence Act of 2013;"

**Effective Dates.** Acts 2013, No. 1496, § 26: Apr. 23, 2013. Emergency clause provided: "It is found and determined by the General Assembly, that the Constitution of the State of Arkansas prohibits the appropriation of funds for more than a one (1) year period; that the effectiveness of this Act on July 1, 2013, is essential to the operation of the agency for which the appropriations in this Act are provided, and that in the event of an extension of the legislative session, the delay in the effective date of this Act beyond July 1, 2013, could work irreparable harm upon the proper administration and provision of essential governmental programs. Therefore, an emergency is hereby declared to exist and Sections 1-20 and 24-25 of this Act being necessary for the immediate preservation of the public peace, health and safety shall be in full

force and effect from and after July 1, 2013. (a) It is found and determined by the General Assembly of the State of Arkansas that the Health Care Independence Program requires private insurance companies to create, present to the Department of Human Services for approval, implement, and market a new kind of insurance policy; and that the private insurance companies need certainty about the law creating the Health Care Independence Program before fully investing time, funds, personnel, and other resources to the development of the new insurance policies. Therefore, an emergency is declared to exist, and Sections 21-23 of this act being immediately necessary for the preservation of the public peace, health, and safety shall become effective on: (1) The date of its approval by the Governor; (2) If the bill is neither approved nor vetoed by the Governor, the expiration of the period of time during which the Governor may veto the bill; or (3) If the bill is vetoed by the Governor and the veto is overridden, the date the last house overrides the veto."

Acts 2013, No. 1497, § 5, and Acts 2013, No. 1498, § 5: Apr. 23, 2013. Emergency clause provided: "It is found and determined by the General Assembly of the State of Arkansas that the Health Care Independence Program requires private insurance companies to create, present to the Department of Human Services for approval, implement, and market a new kind of insurance policy; and that the private insurance companies need certainty about the law creating the Health Care Independence Program before fully investing time, funds, personnel, and other resources to the development of the new insurance policies. Therefore, an emergency is declared to exist, and this act being immediately necessary for the preservation of the public peace, health, and safety shall become effective on: (1) The date of its approval by the Governor; (2) If the bill is neither approved nor vetoed by the Governor, the expiration of the period of time during which the Governor may veto the bill; or (3) If the bill is vetoed by the Governor and the veto is overridden, the date the last house overrides the veto."

**20-77-2401. Title.**

This act shall be known and may be cited as the “Health Care Independence Act of 2013”.

**History.** Acts 2013, No. 1496, § 21; 2013, No. 1497, § 1; 2013, No. 1498, § 1.

**20-77-2402. Legislative intent.**

(a) Notwithstanding any general or specific laws to the contrary, the Department of Human Services is to explore design options that reform the Medicaid program utilizing the Health Care Independence Act of 2013 so that it is a fiscally sustainable, cost-effective, personally responsible, and opportunity-driven program utilizing competitive and value-based purchasing to:

- (1) Maximize the available service options;
- (2) Promote accountability, personal responsibility, and transparency;
- (3) Encourage and reward healthy outcomes and responsible choices; and
- (4) Promote efficiencies that will deliver value to the taxpayers.

(b)(1) It is the intent of the General Assembly that the State of Arkansas through the Department of Human Services utilize a private insurance option for “low-risk” adults.

(2) The Health Care Independence Act of 2013 shall ensure that:

(A) Private health care options increase and government-operated programs such as Medicaid decrease; and

(B) Decisions about the design, operation, and implementation of this option, including cost, remain within the purview of the State of Arkansas and not with Washington, D.C.

**History.** Acts 2013, No. 1496, § 21; 2013, No. 1497, § 1; 2013, No. 1498, § 1.

**20-77-2403. Purpose.**

- (a) The purpose of this subchapter is to:
- (1) Improve access to quality health care;
  - (2) Attract insurance carriers and enhance competition in the Arkansas insurance marketplace;
  - (3) Promote individually-owned health insurance;
  - (4) Strengthen personal responsibility through cost sharing;
  - (5) Improve continuity of coverage;
  - (6) Reduce the size of the state-administered Medicaid program;
  - (7) Encourage appropriate care, including early intervention, prevention, and wellness;
  - (8) Increase quality and delivery system efficiencies;
  - (9) Facilitate Arkansas’s continued payment innovation, delivery system reform, and market-driven improvements;
  - (10) Discourage over-utilization; and



(11) Reduce waste, fraud, and abuse.

(b) The State of Arkansas shall take an integrated and market-based approach to covering low-income Arkansans through offering new coverage opportunities, stimulating market competition, and offering alternatives to the existing Medicaid program.

**History.** Acts 2013, No. 1496, § 21;  
2013, No. 1497, § 1; 2013, No. 1498, § 1.

## **20-77-2404. Definitions.**

As used in this subchapter:

(1) “Carrier” means a private entity certified by the State Insurance Department and offering plans through the Arkansas Health Insurance Marketplace;

(2) “Cost sharing” means the portion of the cost of a covered medical service that must be paid by or on behalf of eligible individuals, consisting of copayments or coinsurance but not deductibles;

(3) “Eligible individuals” means individuals who:

(A) Are adults between nineteen (19) years of age and sixty-five (65) years of age with an income that is equal to or less than one hundred thirty-eight percent (138%) of the federal poverty level, including without limitation individuals who would not be eligible for Medicaid under laws and rules in effect on January 1, 2013;

(B) Have been authenticated to be United States citizens or documented qualified aliens according to the federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104-193, as existing on January 1, 2013; and

(C) Are not determined to be more effectively covered through the standard Medicaid program, such as an individual who is medically frail or other individuals with exceptional medical needs for whom coverage through the Health Insurance Marketplace is determined to be impractical or overly complex, or would undermine continuity or effectiveness of care;

(4) “Healthcare coverage” means healthcare benefits as defined by certification or rules, or both, promulgated by the State Insurance Department for the Qualified Health Plans or available on the marketplace;

(5) “Health Insurance Marketplace” means the vehicle created to help individuals, families, and small businesses in Arkansas shop for and select health insurance coverage in a way that permits comparison of available Qualified Health Plan based upon price, benefits, services, and quality, regardless of the governance structure of the marketplace;

(6) “Independence accounts” mean individual financing structures that operate similar to a health savings account or a medical savings account;

(7) “Premium” means a charge that must be paid as a condition of enrolling in health care coverage;

(8) “Program” means the Health Care Independence Program established by this subchapter; and

(9) “Qualified Health Plan” means a State Insurance Department-certified individual health insurance plan offered by a carrier through the Health Insurance Marketplace.

**History.** Acts 2013, No. 1496, § 21; 2013, No. 1497, § 1; 2013, No. 1498, § 1.

### **20-77-2405. Administration of the Health Care Independence Program.**

- (a) The Department of Human Services shall:
- (1) Create and administer the Health Care Independence Program; and
  - (2)(A) Submit and apply for any:
    - (i) Federal waivers necessary to implement the program in a manner consistent with this subchapter, including without limitation approval for a comprehensive waiver under Section 1115 of the Social Security Act, 42 U.S.C. § 1315; and
    - (ii)(a) Medicaid State Plan Amendments necessary to implement the program in a manner consistent with this subchapter.
- (b) The Department of Human Services shall submit only those Medicaid State Plan Amendments under subdivision (a)(2)(A)(ii)(a) of this section that are optional and therefore may be revoked by the state at its discretion.
- (B)(i) As part of its actions under subdivision (a)(2)(A) of this section, the Department of Human Services shall confirm that employers shall not be subject to the penalties, including without limitation an assessable payment, under Section 1513 of Pub. L. No. 111-148, as existing on January 1, 2013, concerning shared responsibility, for employees who are eligible individuals if the employees:
- (a) Are enrolled in the program; and
  - (b) Enroll in a Qualified Health Plan through the Arkansas Health Insurance Marketplace.
- (ii) If the Department of Human Services is unable to confirm provisions under subdivision (a)(2)(B)(i) of this section, the program shall not be implemented.
- (b)(1) Implementation of the program is conditioned upon the receipt of necessary federal approvals.
- (2) If the Department of Human Services does not receive the necessary federal approvals, the program shall not be implemented.
- (c) The program shall include premium assistance for eligible individuals to enable their enrollment in a Qualified Health Plan through the Arkansas Health Insurance Marketplace.
- (d)(1) The Department of Human Services is specifically authorized to pay premiums and supplemental cost-sharing subsidies directly to the Qualified Health Plan for enrolled eligible individuals.
- (2) The intent of the payments under subdivision (d)(1) of this section is to increase participation and competition in the Health Insurance Marketplace, intensify price pressures, and reduce costs for both publicly and privately funded health care.



(e) To the extent allowable by law:

(1) The Department of Human Services shall pursue strategies that promote insurance coverage of children in their parents' or caregivers' plan, including children eligible for the ARKids First Program Act, § 20-77-1101 et seq., commonly known as the "ARKids B program";

(2) Upon the receipt of necessary federal approval, during calendar year 2015 the Department of Human Services shall include and transition to the Arkansas Health Insurance Marketplace:

(A) Children eligible for the ARKids First Program Act, § 20-77-1101 et seq.; and

(B) Populations under Medicaid from zero percent (0%) of the federal poverty level to seventeen percent (17%) of the federal poverty level; and

(3) The Department of Human Services shall develop and implement a strategy to inform Medicaid recipient populations whose needs would be reduced or better served through participation in the Arkansas Health Insurance Marketplace.

(f) The program shall include allowable cost sharing for eligible individuals that is comparable to that for individuals in the same income range in the private insurance market and is structured to enhance eligible individuals' investment in their healthcare purchasing decisions.

(g)(1) The State Insurance Department and Department of Human Services shall administer and promulgate rules to administer the program authorized under this subchapter.

(2) No less than thirty (30) days before the State Insurance Department and Department of Human Services begin promulgating a rule under this subchapter, the proposed rule shall be presented to the Legislative Council.

(h) The program authorized under this subchapter shall terminate within one hundred twenty (120) days after a reduction in any of the following federal medical assistance percentages:

(1) One hundred percent (100%) in 2014, 2015, or 2016;

(2) Ninety-five percent (95%) in 2017;

(3) Ninety-four percent (94%) in 2018;

(4) Ninety-three percent (93%) in 2019; and

(5) Ninety percent (90%) in 2020 or any year after 2020.

(i) An eligible individual enrolled in the program shall affirmatively acknowledge that:

(1) The program is not a perpetual federal or state right or a guaranteed entitlement;

(2) The program is subject to cancellation upon appropriate notice; and

(3) The program is not an entitlement program.

(j)(1) The Department of Human Services shall develop a model and seek from the Centers for Medicare & Medicaid Services all necessary waivers and approvals to allow non-aged, non-disabled program-eli-

gible participants to enroll in a program that will create and utilize independence accounts that operate similarly to a health savings account or medical savings account during the calendar year 2015.

(2) The independence accounts shall:

(A) Allow a participant to purchase cost-effective high-deductible health insurance; and

(B) Promote independence and self-sufficiency.

(3) The state shall implement cost sharing and co-pays and, as a condition of participation, earnings shall exceed fifty percent (50%) of the federal poverty level.

(4) Participants may receive rewards based on healthy living and self-sufficiency.

(5)(A) At the end of each fiscal year, if there are funds remaining in the account, a majority of the state's contribution will remain in the participant's control as a positive incentive for the responsible use of the healthcare system and personal responsibility of health maintenance.

(B) Uses of the funds may include without limitation rolling the funds into a private sector health savings account for the participant according to rules promulgated by the Department of Human Services.

(6) The Department of Human Services shall promulgate rules to implement this subsection (j).

(k)(1) State obligations for uncompensated care shall be projected, tracked, and reported to identify potential incremental future decreases.

(2) The Department of Human Services shall recommend appropriate adjustments to the General Assembly.

(3) Adjustments shall be made by the General Assembly as appropriate.

(l) The Department of Human Services shall track the hospital assessment under § 20-77-1902 and report to the General Assembly subsequent decreases based upon reduced uncompensated care.

(m) On a quarterly basis, the Department of Human Services and the State Insurance Department shall report to the Legislative Council, or to the Joint Budget Committee if the General Assembly is in session, available information regarding:

(1) Program enrollment;

(2) Patient experience;

(3) Economic impact including enrollment distribution;

(4) Carrier competition; and

(5) Avoided uncompensated care.

**History.** Acts 2013, No. 1496, § 21; 2013, No. 1497, § 1; 2013, No. 1498, § 1.

**A.C.R.C. Notes.** Pursuant to Acts 2013, No. 1498, § 4, this section is set out as amended by Acts 2013, No. 1498, § 1.

Acts 2013, No. 1496, § 21, enacted sub-

sections (a) and (j) to read as follows:

"(a) The Department of Human Services shall:

"(1) Create and administer the Health Care Independence Program; and

"(2) Submit Medicaid State Plan



Amendments and apply for any federal waivers necessary to implement the program in a manner consistent with this subchapter.

“(j)(1) The Department of Human Services shall develop a model and seek approval from the Center for Medicare and Medicaid Services to allow a limited number of enrollees to participate in a pilot program testing the viability of a Health

Savings Account or a Medical Savings Account.

“(2) The pilot program shall be implemented during calendar year 2015.

“(3) As soon as practicable, the Department of Human Services shall seek conditional federal approval to place Health Saving Accounts and Medical Savings Accounts on the Health Insurance Marketplace.”

## **20-77-2406. Standards of healthcare coverage through the Health Insurance Marketplace.**

(a) Healthcare coverage shall be achieved through a qualified health plan at the silver level as provided in 42 U.S.C. §§ 18022 and 18071, as existing on January 1, 2013, that restricts cost sharing to amounts that do not exceed Medicaid cost-sharing limitations.

(b)(1) All participating carriers in the Arkansas Health Insurance Marketplace shall offer healthcare coverage conforming to the requirements of this subchapter.

(2) A participating carrier in the Arkansas Health Insurance Marketplace shall maintain a medical loss ratio of at least eighty percent (80%) for an individual and small group market policy and at least eighty-five percent (85%) for a large group market policy as required under Pub. L. No. 111-148, as existing on January 1, 2013.

(c) To assure price competitive choice among healthcare coverage options, the State Insurance Department shall assure that at least two (2) qualified health plans are offered in each county in the state.

(d) Health insurance carriers offering health care coverage for program eligible individuals shall participate in Health Care Payment Improvement Initiative including:

- (1) Assignment of primary care clinician;
- (2) Support for patient-centered medical home; and
- (3) Access of clinical performance data for providers.

(e) On or before July 1, 2013, the State Insurance Department shall implement through certification requirements or rules, or both, the applicable provisions of this subchapter.

**History.** Acts 2013, No. 1496, § 21; 2013, No. 1497, § 1; 2013, No. 1498, § 1.

## **20-77-2407. Enrollment.**

(a) The General Assembly shall assure that a mechanism within the Arkansas Health Insurance Marketplace is established and operated to facilitate enrollment of eligible individuals.

(b) The enrollment mechanism shall include an automatic verification system to guard against waste, fraud, and abuse in the program.

**History.** Acts 2013, No. 1496, § 21; 2013, No. 1497, § 1; 2013, No. 1498, § 1.

**20-77-2408. Effective date.**

This subchapter shall be in effect until June 30, 2017, unless amended or extended by the General Assembly.

**History.** Acts 2013, No. 1496, § 21; 2013, No. 1497, § 1; 2013, No. 1498, § 1.

**SUBCHAPTER 25 — OFFICE OF MEDICAID INSPECTOR GENERAL**

## SECTION.

- 20-77-2501. Purpose.
- 20-77-2502. Definitions.
- 20-77-2503. Office of Medicaid Inspector General — Created.
- 20-77-2504. Medicaid Inspector General — Appointment — Qualifications.
- 20-77-2505. Office of Medicaid Inspector General — Powers and duties.
- 20-77-2506. Medicaid Inspector General — Duties.
- 20-77-2507. Cooperation of agency officials and employees.

## SECTION.

- 20-77-2508. Transfer of duties and resources.
- 20-77-2509. Reports required of the Medicaid Inspector General.
- 20-77-2510. Department of Human Services consultation with Office of Medicaid Inspector General.
- 20-77-2511. Provider compliance program.
- 20-77-2512. Applicability of the Medicaid Fairness Act.

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**Effective Dates.** Acts 2013, No. 1499, § 5: July 1, 2013. Emergency clause provided: "It is found and determined by the General Assembly of the State of Arkansas that the oversight and audit of the state's Medicaid program is essential to its continued operation; that the creation of the Office of the Medicaid Inspector General will ensure that fraud, waste, and

abuse are found in a timely manner; and that this act is necessary to ensure that state and federal monies are not misspent. Therefore, an emergency is declared to exist, and this act being necessary for the preservation of the public peace, health, and safety shall become effective on July, 1, 2013."

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**20-77-2501. Purpose.**

The purpose of this subchapter is to:

- (1) Consolidate staff and other Medicaid fraud detection, prevention, and recovery functions from the relevant governmental entities into a single office;
- (2) Create a more efficient and accountable structure;
- (3) Reorganize and streamline the state's process for detecting and combating Medicaid fraud and abuse; and
- (4) Maximize the recovery of improper Medicaid payments.

**History.** Acts 2013, No. 1499, § 2.



**20-77-2502. Definitions.**

As used in this subchapter:

(1)(A) “Abuse” means provider practices that are inconsistent with sound fiscal, business, or medical practices and result in an unnecessary cost to the Medicaid program or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care.

(B) “Abuse” includes recipient practices that result in an unnecessary cost to the Medicaid program;

(2)(A) “Fraud” means a purposeful deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to the person or another person.

(B) “Fraud” includes any act that constitutes fraud under applicable federal or state law;

(3) “Health plan” means a publicly or privately funded health insurance or managed care plan or contract under which a healthcare item or service is provided and through which payment is made to the person who provided the healthcare item or service;

(4) “Investigation” means investigations of fraud, abuse, or illegal acts perpetrated within the medical assistance program by providers or recipients of medical assistance care, services, and supplies;

(5) “Person” means an individual or entity other than a recipient of a healthcare item or service;

(6) “Recovery” means any action or attempt by the inspector to recoup or collect Medicaid payments already made to a provider with respect to a claim by:

(A) Reducing other payments currently owed to the provider;

(B) Withholding or setting off the amount against current or future payments to the provider;

(C) Demanding payment back from a provider for a claim already paid; or

(D) Reducing or affecting in any other manner the future claim payments to the provider;

(7) “Single health plan” includes without limitation the Arkansas Medicaid Program; and

(8) “Waste” means that taxpayers are not receiving reasonable value for money in connection with a government-funded activity due to an inappropriate act or omission involving mismanagement, inappropriate actions, and inadequate oversight by the person with control over or access to government resources.

**History.** Acts 2013, No. 1499, § 2.

**20-77-2503. Office of Medicaid Inspector General — Created.**

The Office of Medicaid Inspector General is created within the office of the Governor and is independent from the Department of Human Services.

**History.** Acts 2013, No. 1499, § 2.

#### **20-77-2504. Medicaid Inspector General — Appointment — Qualifications.**

(a)(1) The Medicaid Inspector General shall be appointed by the Governor, with the advice and consent of the Senate.

(2) The inspector shall serve at the pleasure of the Governor.

(b) The inspector shall report directly to the Governor.

(c) The Medicaid Inspector General shall be the director of the Office of Medicaid Inspector General.

(d) The inspector shall have not less than ten (10) years of professional experience in one (1) or more of the following areas of expertise:

(1) Prosecution for fraud;

(2) Fraud investigation;

(3) Auditing; or

(4) Comparable alternate experience in health care, if the healthcare experience involves some consideration of fraud.

**History.** Acts 2013, No. 1499, § 2.

#### **20-77-2505. Office of Medicaid Inspector General — Powers and duties.**

The Office of Medicaid Inspector General shall:

(1) Prevent, detect, and investigate fraud and abuse within the medical assistance program;

(2) Refer appropriate cases for criminal prosecution;

(3) Recover improperly expended medical assistance funds;

(4) Audit medical assistance program functions; and

(5) Establish a medical assistance fraud and abuse prevention program.

**History.** Acts 2013, No. 1499, § 2.

#### **20-77-2506. Medicaid Inspector General — Duties.**

The Medicaid Inspector General shall:

(1) Hire deputies, directors, assistants, and other officers and employees needed for the performance of his or her duties and prescribe the duties of deputies, directors, assistants, and other officers and fix the compensation of deputies, directors, assistants, and other officers within the amounts appropriated;

(2)(A) Conduct and supervise activities to prevent, detect, and investigate medical assistance program fraud and abuse.

(B)(i) The Office of Medicaid Inspector General shall review provider records only for the three (3) years before an investigation begins.

(ii) However, if a credible allegation of fraud has been made or if the office has reason to believe that fraud has occurred, the office may



review provider records for the five (5) years before the investigation began;

(3) Work in a coordinated and cooperative manner with:

(A) Federal, state, and local law enforcement agencies;

(B) The Medicaid Fraud Control Unit of the office of the Attorney General;

(C) United States Attorneys;

(D) United States Department of Health and Human Services's Office of Inspector General;

(E) The Federal Bureau of Investigation;

(F) The Drug Enforcement Administration;

(G) Prosecuting attorneys;

(H) The Centers for Medicare & Medicaid Services; and

(I) An investigative unit maintained by a health insurer;

(4) Solicit, receive, and investigate complaints related to fraud and abuse within the medical assistance program;

(5)(A) Inform the Governor, the Attorney General, the President Pro Tempore of the Senate, and the Speaker of the House of Representatives regarding efforts to prevent, detect, investigate, and prosecute fraud and abuse within the medical assistance program.

(B) All cases in which fraud is determined to have occurred shall be referred to the appropriate law enforcement agency for prosecution;

(6)(A) Pursue civil and administrative enforcement actions against an individual or entity that engages in fraud, abuse, or illegal or improper acts within the medical assistance program, including without limitation:

(i) Referral of information and evidence to regulatory agencies and licensure boards;

(ii) Withholding payment of medical assistance funds in accordance with state laws and rules and federal laws and regulations;

(iii) Imposition of administrative sanctions and penalties in accordance with state laws and rules and federal laws and regulations;

(iv) Exclusion of providers, vendors, and contractors from participation in the medical assistance program;

(v) Initiating and maintaining actions for civil recovery and, where authorized by law, seizure of property or other assets connected with improper payments;

(vi) Entering into civil settlements; and

(vii) Recovery of improperly expended medical assistance program funds from those who engage in fraud or abuse or illegal or improper acts perpetrated within the medical assistance program.

(B) In investigating civil and administrative enforcement actions under subdivision (a)(6)(A) of this section, the inspector shall consider the quality and availability of medical care and services and the best interest of both the medical assistance program and recipients;

(7) Make available to appropriate law enforcement officials information and evidence relating to suspected criminal acts that have been obtained in the course of the inspector's duties;

(8)(A) Refer suspected fraud or criminal activity to the Medicaid Fraud Control Unit of the office of the Attorney General.

(B) After a referral and with ten (10) days' written notice to the Medicaid Fraud Control Unit of the office of the Attorney General, the inspector may provide relevant information about suspected fraud or criminal activity to another federal or state law enforcement agency that the inspector deems appropriate under the circumstances;

(9) Subpoena and enforce the attendance of witnesses, administer oaths or affirmations, examine witnesses under oath, and take testimony in connection with an investigation or audit under this subchapter and under rules governing these investigations;

(10) Require and compel the production of books, papers, records, and documents as he or she deems relevant or material to an investigation, examination, or review undertaken under this section;

(11)(A) Examine and copy or remove documents or records related to the medical assistance program or necessary for the inspector to perform his or her duties if the documents are prepared, maintained, or held by or available to a state agency or local governmental entity the patients or clients of which are served by the medical assistance program, or the entity is otherwise responsible for the control of fraud and abuse within the medical assistance program.

(B) A document or record examined and copied or removed by the inspector under subdivision (11)(A) of this section is confidential.

(C) The removal of a record under subdivision (11)(A) of this section is limited to circumstances in which a copy of the record is insufficient for an appropriate legal or investigative purpose.

(D) For a removal under subdivision (11)(A) of this section, the inspector shall copy the record and ensure the expedited return of the original, or of a copy if the original is required for an appropriate legal or investigative purpose, so that the information is expedited and the original or copy is readily accessible for the care and treatment needs of the patient;

(12)(A) Recommend and implement policies relating to the prevention and detection of fraud and abuse.

(B) The inspector shall obtain the consent of the Attorney General before the implementation of a policy under subdivision (12)(A) of this section that may affect the operations of the office of the Attorney General;

(13)(A) Monitor the implementation of a recommendation made by the office to an agency or other entity with responsibility for administration of the medical assistance program and produce a report detailing the results of its monitoring activity as necessary.

(B) The report shall be submitted to the:

- (i) Governor;
- (ii) President Pro Tempore of the Senate;
- (iii) Speaker of the House of Representatives;
- (iv) Legislative Council;
- (v) Division of Legislative Audit; and



(vi) Attorney General;

(14) Prepare cases, provide testimony, and support administrative hearings and other legal proceedings;

(15) Review and audit contracts, cost reports, claims, bills, and other expenditures of medical assistance program funds to determine compliance with applicable state laws and rules and federal laws and regulations and take actions authorized by state laws and rules and federal laws and regulations;

(16)(A) Work with the fiscal agent employed to operate the Medicaid Management Information System of the Department of Human Services to optimize the system, including without limitation the ability to add edits and audits in consultation with the Department of Human Services.

(B) The inspector shall be consulted before an edit or audit is added or discontinued by the Department of Human Services;

(17) Work in a coordinated and cooperative manner with relevant agencies in the implementation of information technology relating to the prevention and identification of fraud and abuse in the medical assistance program;

(18)(A) Conduct educational programs for medical assistance program providers, vendors, contractors, and recipients designed to limit fraud and abuse within the medical assistance program.

(B) The office shall regularly communicate with and educate providers about the office's fraud and abuse prevention program and its audit policies and procedures.

(C) The office shall educate providers annually concerning its areas of focus within the medical assistance program, appropriate billing and documentation, and methods for improving compliance with program rules, policies, and procedures;

(19)(A) Develop protocols to facilitate the efficient self-disclosure consistent with the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, and the collection of overpayments and monitor collections, including those that are self-disclosed by providers.

(B) A provider's good faith self-disclosure of overpayments may be considered as a mitigating factor in the determination of an administrative enforcement action;

(20) Receive and investigate complaints of alleged failures of state and local officials to prevent, detect, and prosecute fraud and abuse in the medical assistance program;

(21) Implement rules relating to the prevention, detection, investigation, and referral of fraud and abuse within the medical assistance program and to the recovery of improperly expended medical assistance program funds;

(22) Conduct, in the context of the investigation of fraud and abuse, on-site inspections of a facility or an office;

(23)(A) Take appropriate authorized actions to ensure that the medical assistance program is the payor of last resort; and

- (B) Recommend to the department that it take appropriate actions authorized under the department's jurisdiction to ensure that the medical assistance program is the payor of last resort;
- (24) Annually submit a budget request for the next state fiscal year to the Governor;
- (25) Identify and order the return of underpayments to providers;
- (26) Maintain the confidentiality of all information and documents that are deemed confidential by law;
- (27) Implement, facilitate, and maintain federally required directives and contracts required for Medicaid integrity programs;
- (28) Implement and maintain a hotline for reporting complaints regarding fraud, waste, and abuse by providers;
- (29) Audit, investigate, and access Medicaid encounter data, premium data, or other information from an entity contracted with for the purpose of serving Medicaid programs;
- (30)(A) Promulgate administrative rules to establish policies and procedures for audits and investigations that are consistent with the duties of the office under this chapter.
- (B) The rules shall be posted on the office's website;
- (31) Identify conflicts between the Medicaid state plan, department rules, Medicaid provider manuals, Medicaid notices, or other guidance and recommend that the department reconcile inconsistencies;
- (32) When conducting an audit, investigation, or review under this subchapter, classify violations as either:
- (A) Errors that do not rise to the level of fraud or abuse; or
- (B) Fraud or abuse;
- (33)(A) If a credible allegation of fraud has been made, review provider records that have been the subject of a previous audit or review for the purpose of fraud investigation and referral.
- (B) However, the Medicaid Inspector General shall not duplicate an audit of a contract, cost report, claim, bill, or expenditure of a medical assistance program fund that has been the subject of a previous audit or review by or on behalf of the Office of Medicaid Inspector General, the Medicaid Fraud Control Unit, or other federal agency with authority over the medical assistance program if the audit or review was performed in accordance with Government Auditing Standards;
- (34)(A) Utilize a quality improvement organization as part of the assessment of quality of services.
- (B) The quality improvement organization shall refer all identified improper payments due to technical deficiencies, abuse, waste, or fraud to the Medicaid Inspector General for further investigation and appropriate action, including without limitation recovery; and
- (35) Perform other functions necessary or appropriate to fulfill the duties and responsibilities of the office.



**20-77-2507. Cooperation of agency officials and employees.**

(a)(1) The Medicaid Inspector General shall request information, assistance, and cooperation from a federal, state, or local governmental department, board, bureau, commission, or other agency or unit of an agency to carry out the duties under this section.

(2) A state or local agency or unit of an agency shall provide information, assistance, and cooperation under this section.

(b) Upon request of a prosecuting attorney, the following entities shall provide information and assistance as the entity deems necessary, appropriate, and available to aid the prosecutor in the investigation of fraud and abuse within the medical assistance program and the recovery of improperly expended funds:

(1) The Office of Medicaid Inspector General;

(2) The Department of Human Services;

(3) The Medicaid Fraud Control Unit of the office of the Attorney General; and

(4) Another state or local government entity.

(c) All tips to the Arkansas Medicaid Fraud and Abuse Hotline under § 20-77-2506(28) that include an allegation of fraud shall be forwarded to the office.

**History.** Acts 2013, No. 1499, § 2.

**20-77-2508. Transfer of duties and resources.**

(a) The duties, functions, records, personnel, property, unexpended balances of appropriations, allocations, or other funds of the Department of Human Services necessary to the operations of the Office of Medicaid Inspector General under § 20-77-2505 are transferred to the office.

(b) The office shall assume the duties under the Medical Assistance Programs Integrity Law, § 20-77-1301 et seq.

**History.** Acts 2013, No. 1499, § 2.

**20-77-2509. Reports required of the Medicaid Inspector General.**

(a) The Medicaid Inspector General shall, no later than October 1 of each year, submit to the Governor, the President Pro Tempore of the Senate, the Speaker of the House of Representatives, Division of Legislative Audit, Legislative Council, and the Attorney General a report summarizing the activities of the Office of Medicaid Inspector General during the preceding calendar year.

(b) The report required under subsection (a) of this section shall include without limitation:

(1) The number, subject, and other relevant characteristics of:

(A) Investigations initiated and completed, including without limitation outcome, region, source of complaint, and whether or not the investigation was conducted jointly with the Attorney General;

(B) Audits initiated and completed, including without limitation outcome, region, the reason for the audit, the total state and federal dollar value identified for recovery, the actual state and federal recovery from the audits, and the amount repaid to the Centers for Medicare & Medicaid Services;

(C) Administrative actions initiated and completed, including without limitation outcome, region, and type;

(D)(i) Referrals for prosecution to the Attorney General and to federal or state law enforcement agencies and referrals to licensing authorities.

(ii) Information reported under subdivision (b)(1)(D)(i) of this section shall include without limitation the status and region of an administrative action;

(E) Civil actions initiated by the office related to improper payments, the resulting civil settlements entered, overpayments identified, and the total dollar value identified and collected; and

(F) Administrative and education activities conducted to improve compliance with Medicaid program policies and requirements; and  
(2)(A) A narrative that evaluates the office's performance, describes specific problems with the procedures and agreements required under this section, discusses other matters that may have impaired the office's effectiveness, and summarizes the total savings to the state medical assistance program.

(B)(i) In addition to total savings, the narrative shall detail net savings in state funds.

(ii) As used in subdivision (b)(2)(B)(i) of this section, "net savings" means amounts recovered by the office less payments made to the Centers for Medicare & Medicaid Services and the costs of state administrative procedures.

(c) The office may subpoena individuals, books, electronic and other records, and documents that are necessary for the completion of reports under this section.

(d)(1) In making the report required under subsection (a) of this section, the inspector shall not disclose information that jeopardizes an ongoing investigation or proceeding.

(2) The inspector may disclose information in the report required under subsection (a) of this section if the information does not jeopardize an ongoing investigation or proceeding and the inspector fully apprises the designated recipients of the scope and quality of the office's activities.

(e) Quarterly by April 1, July 1, October 1, and January 1 of each year, the inspector shall submit to the Governor, the President Pro Tempore of the Senate, the Speaker of the House of Representatives, Division of Legislative Audit, Legislative Council, and the Attorney General an accountability statement providing a statistical profile of



the referrals made to the Medicaid Fraud Control Unit of the office of the Attorney General, audits, investigations, and recoveries.

**History.** Acts 2013, No. 1499, § 2.

**20-77-2510. Department of Human Services consultation with Office of Medicaid Inspector General.**

(a) The Department of Human Services shall consult with the Office of Medicaid Inspector General regarding an activity undertaken by a fiscal intermediary or fiscal agent pertaining to suspected fraud, waste, or abuse.

(b) The department, in consultation with the office, shall:

(1) Develop, test, recommend, and implement methods to strengthen the capability of the Medicaid Management Information System to detect and control fraud, waste, and abuse and improve expenditure accountability;

(2)(A) Enter into agreement with a fiscal agent in collaboration with the Office of Medicaid Inspector General's data mining technology to develop, test, and implement the new methods under subdivision (b)(1) of this section.

(B) A collaborative agreement with the office under subdivision (b)(2)(A) of this section shall be made with an agent that has demonstrated expertise in the areas addressed by the agreement;

(3)(A) Develop, test, recommend, and implement an automated process to improve the coordination of benefits between the medical assistance program and other sources of coverage for medical assistance recipients.

(B)(i) An automated process under subdivision (b)(3)(A) of this section initially shall examine the savings potential to the medical assistance program through retrospective review of claims paid.

(ii) The examination under subdivision (b)(3)(B)(i) of this section shall be completed no later than January 1, 2014.

(iii) If, based upon the initial experience under subdivision (b)(3)(B)(i) of this section, the Medicaid Inspector General deems the automated process to be capable of including or moving to a prospective review with negligible effect on the turnaround of claims for provider payment or on recipient access to services, the inspector in subsequent tests shall examine the savings potential through prospective, pre-claims payment review;

(4) Take all reasonable and necessary actions to intensify the state's current level of monitoring, analyzing, reporting, and responding to medical assistance program claims data maintained by the state's Medicaid Management Information System fiscal agents and ensure that any data abnormalities identified are reported to the office for appropriate action;

(5) Make efforts to improve the utilization of data in order to better assist the office in identifying fraud and abuse within the medical assistance program and to identify and implement further program and patient care reforms for the improvement of the program;

(6) Identify additional data elements that are maintained and otherwise accessible by the state, directly or through any of its contractors, that would, if coordinated with medical assistance data, further assist the office in increasing the effectiveness of data analysis for the management of the medical assistance program;

(7) Provide or arrange in-service training for state and county medical assistance personnel to increase the capability for state and local data analysis to move toward a more cost-effective operation of the medical assistance program;

(8)(A) No later than January 1, 2014, assist the office in developing, testing, and implementing an automated process for the targeted review of claims, services, and populations or a combination of claims, services, and populations.

(B) A review under subdivision (b)(8)(A) of this section is to identify statistical aberrations in the use or billing of the services and to assist in the development and implementation of measures to ensure that service use and billing are appropriate to recipients' needs; and

(9) Pay providers for underpayments identified through actions of the office.

(c)(1) The methods developed and recommended under subdivision (b)(1) of this section shall address without limitation the development, testing, and implementation of an automated claims review process that, before payment, shall subject a medical assistance program services claim to review for proper coding and another review as may be necessary.

(2) Services subject to review shall be based on:

(A) The expected cost-effectiveness of reviewing the service;

(B) The capabilities of the automated system for conducting the review; and

(C) The potential to implement the review with negligible effect on the turnaround of claims for provider payment or on recipient access to necessary services.

(3) A review under subdivision (c)(2) of this section shall be designed to provide for the efficient and effective operation of the medical assistance program claims payment system by performing functions, including without limitation:

(A) Capturing coding errors, misjudgments, or incorrect or multiple billing for the same service; and

(B) Possible excesses in billing or service use, whether intentional or unintentional.

(d)(1) No later than December 1, 2013, the Director of the Department of Human Services in conjunction with the office shall prepare and submit an interim report to the Governor and the cochairs of the Legislative Council on the implementation of the initiatives under this section.

(2) The report under subdivision (d)(1) of this section shall also include a recommendation for a revision that would further facilitate the goals of this section, including recommendations for expansion.



(e) Applicable medical assistance program rules, provider manuals, and administrative policies, procedures, and guidance will be posted on the Office of Medicaid Inspector General website, or by a link from the website to the department's website.

**History.** Acts 2013, No. 1499, § 2.

### **20-77-2511. Provider compliance program.**

(a) The General Assembly finds that:

(1) Medical assistance providers potentially are able to detect and correct payment and billing mistakes and fraud if required to develop and implement compliance programs;

(2) A provider compliance program makes it possible to organize provider resources to resolve payment discrepancies, detect inaccurate billings as quickly and efficiently as possible, and to impose systemic checks and balances to prevent future recurrences;

(3) It is in the public interest that providers within the medical assistance program implement compliance programs;

(4) The wide variety of provider types in the medical assistance program necessitates a variety of compliance programs that reflect a provider's size, complexity, resources, and culture;

(5) For a compliance program to be effective, it must be designed to be compatible with the provider's characteristics;

(6) Key components shall be included in each compliance program if a provider is to be a medical assistance program participant; and

(7) A provider should adopt and implement an effective compliance program appropriate to the provider.

(b) A provider of medical assistance program items and services that receives annually seven hundred fifty thousand dollars (\$750,000) or more through the state Medicaid program shall adopt and implement a compliance program.

(c)(1) The Office of Medicaid Inspector General shall create and make available on its website guidelines including a model compliance program.

(2) A model compliance program under subdivision (c)(1) of this section shall be applicable to billings to and payments from the medical assistance program but need not be confined to billings and payments.

(3) The model compliance program required under subdivision (c)(1) of this section may be a component of a more comprehensive compliance program by the medical assistance provider if the comprehensive compliance program meets the requirements of this section.

(d) A compliance program shall include without limitation:

(1) A written policy and procedure that:

(A) Describes compliance expectations;

(B) Describes the implementation of the operation of the compliance program;

(C) Provides guidance to employees and others on dealing with potential compliance issues;

(D) Identifies a method for communicating compliance issues to appropriate compliance personnel; and

(E) Describes the method by which potential compliance problems are investigated and resolved;

(2)(A) Designation of an employee vested with responsibility for the operation of the compliance program.

(B) The designated employee's duties may solely relate to compliance or may be combined with other duties if compliance responsibilities are satisfactorily carried out.

(C) The designated employee shall report directly to the entity's chief executive or other senior administrator and periodically shall report directly to the governing body of the provider on the activities of the compliance program;

(3)(A) Training and education of affected employees and persons associated with the provider, including executives and governing body members, on compliance issues, expectations, and the compliance program operation.

(B) The training under subdivision (d)(3)(A) of this section shall occur periodically and shall be made a part of the orientation for a new employee, appointee, associate, executive, or governing body member;

(4)(A) Lines of communication to the designated compliance employee that are accessible to all employees, persons associated with the provider, executives, and governing body members to allow compliance issues to be reported.

(B) The lines of communication under subdivision (d)(4)(A) of this section shall include a method for anonymous and confidential good-faith reporting of potential compliance issues as they are identified;

(5) Disciplinary policies to encourage good-faith participation in the compliance program by an affected individual, including a policy that articulates expectations for reporting compliance issues and assisting in their resolution and outlines sanctions for:

(A) Failing to report suspected problems;

(B) Participating in noncompliant behavior; and

(C) Encouraging, directing, facilitating, or permitting noncompliant behavior;

(6) A system for routine identification of compliance risk areas specific to the provider type for:

(A) Self-evaluation of the risk areas, including internal audits and as appropriate external audits; and

(B) Evaluation of potential or actual noncompliance as a result of the self-evaluations and audits;

(7) A system for:

(A) Responding to compliance issues as they are raised;

(B) Investigating potential compliance problems;

(C) Responding to compliance problems as identified in the course of self-evaluations and audits;



(D) Correcting problems promptly and thoroughly and implementing procedures, policies, and systems to reduce the potential for recurrence;

(E) Identifying and reporting compliance issues to the Department of Human Services or the office; and

(F) Refunding overpayments; and

(8) A policy of nonintimidation and nonretaliation for good-faith participation in the compliance program, including without limitation:

(A) Reporting potential issues;

(B) Investigating issues;

(C) Self-evaluations;

(D) Audits and remedial actions; and

(E) Reporting to appropriate officials.

(e)(1) Upon enrollment in the medical assistance program, a provider shall certify to the department that the provider satisfactorily meets the requirements of this section.

(2) The Medicaid Inspector General shall determine whether a provider has a compliance program that satisfactorily meets the requirements of this section by requesting no more than one (1) time every year an updated certification that the provider satisfactorily meets the requirements of this section.

(f) A compliance program that is accepted by the United States Department of Health and Human Services's Office of Inspector General and remains in compliance with the standards of the Office of Medicaid Inspector General is in compliance with this section.

(g) If the inspector finds that a provider does not have a satisfactory compliance program within ninety (90) days after the effective date of a rule adopted under this section, the provider is subject to any sanction or penalty permitted by a state law or rule or a federal law or regulation, including revocation of the provider's agreement to participate in the medical assistance program.

(h)(1) The Office of Medicaid Inspector General shall adopt rules to implement this section.

(2) The rules shall be subject to review by the Legislative Council.

**History.** Acts 2013, No. 1499, § 2.

## **20-77-2512. Applicability of the Medicaid Fairness Act.**

The Medicaid Fairness Act, § 20-77-1701 et seq., applies to this subchapter.

**History.** Acts 2013, No. 1499, § 2.

## **CHAPTER 78**

## **CHILD CARE**

### **SUBCHAPTER.**

#### **1. GENERAL PROVISIONS.**

SUBCHAPTER

- 2. LICENSING OF FACILITIES.
- 5. EARLY CHILDHOOD COMMISSION.
- 6. BACKGROUND CHECKS OF CHILD CARE FACILITY LICENSEES AND EMPLOYEES.
- 8. BIRTH THROUGH PREKINDERGARTEN TEACHING CREDENTIAL AND ENDORSEMENT.
- 9. HOME VISITATION.

SUBCHAPTER 1 — GENERAL PROVISIONS

SECTION.

- 20-78-104. Child Health and Family Life Institute.
- 20-78-106. Availability of records from children’s advocacy centers, hospitals, or clinics during an investigation of suspected cases of child abuse or neglect.

SECTION.

- 20-78-107. Criminal background checks for employees of private businesses that provide short-term child care for patrons.

20-78-104. Child Health and Family Life Institute.

(a)(1) The Child Health and Family Life Institute shall be administered under the direction of Arkansas Children’s Hospital.

(2) Arkansas Children’s Hospital shall enter into a cooperative agreement or contract with the Department of Pediatrics of the University of Arkansas for Medical Sciences for services required in delivering the programs of the institute.

(3) The KIDS FIRST Program, a component of the Child Health and Family Life Institute, shall receive priority consideration above all other programs of the institute when funding decisions are made by Arkansas Children’s Hospital.

(4) Arkansas Children’s Hospital shall make quarterly reports to the Legislative Council on matters of funding, existing programs, and any new programs and services offered through the institute.

(b)(1) The Chancellor of the University of Arkansas for Medical Sciences shall designate an individual from the department who shall provide administrative oversight of the cooperative agreements or contract with Arkansas Children’s Hospital in delivering the programs of the institute.

(2) The department shall make every effort to advance the KIDS FIRST Program statewide.

(3) The designated administrator from the department shall make quarterly reports to the Chancellor and the Legislative Council on all matters of funding, existing programs, and services offered through the institute.

**History.** Acts 1995, No. 1099, § 27; 1995, No. 1198, § 96.

**A.C.R.C. Notes.** Acts 2013, No. 1403, § 38, provided: “CHILD AND FAMILY LIFE INSTITUTE. The Child Health and Family Life Institute shall be adminis-

tered under the direction of Arkansas Children’s Hospital. Arkansas Children’s Hospital shall enter into a cooperative agreement and/or contract with the University of Arkansas for Medical Sciences-Department of Pediatrics for services re-



quired to deliver the programs of the Child Health and Family Life Institute (CHFLI). Utilizing a multidisciplinary collaboration of professionals, CHFLI shall provide a statewide effort to explore, develop and evaluate new and better ways to address medically, socially and economically interrelated health and developmental needs of children with special health care needs and their families. CHFLI priorities shall include, but are not limited to, wellness and prevention, screen and diagnosis, treatment and intervention, training and education and research and evaluation. Arkansas Children's Hospital and the University of Arkansas for Medical Sciences-Department of Pediatrics shall make annual reports to the Arkansas Legislative Council on all matters of funding, existing programs and services offered through CHFLI.

"The provisions of this section shall be in effect only from July 1, 2013 through June 30, 2014."

Acts 2013, No. 1496, § 12, provided: "MEDICAL SERVICES — CHILD AND FAMILY LIFE INSTITUTE. The Child Health and Family Life Institute shall be administered under the direction of Arkansas Children's Hospital. Arkansas Children's Hospital shall enter into a co-

operative agreement and/or contract with the University of Arkansas for Medical Sciences — Department of Pediatrics for services required in delivering the programs of the Child Health and Family Life Institute. Utilizing a multidisciplinary collaboration of professionals, the Child Health and Family Life Institute shall provide a statewide effort to explore, develop and evaluate new and better ways to address medically, socially and economically interrelated health and developmental needs of children with special health care needs and their families. The Child Health and Family Life Institute's priorities shall include, but are not limited to, wellness and prevention, screen and diagnosis, treatment and intervention, training and education and research and evaluation.

"Arkansas Children's Hospital and the University of Arkansas for Medical Sciences — Department of Pediatrics shall make annual reports to the Arkansas Legislative Council on all matters of funding, existing programs and services offered through the Child Health and Family Life Institute.

"The provisions of this section shall be in effect only from July 1, 2013 through June 30, 2014."

**20-78-106. Availability of records from children's advocacy centers, hospitals, or clinics during an investigation of suspected cases of child abuse or neglect.**

(a) Reports, correspondence, memoranda, case histories, medical records, or other materials compiled or gathered during an investigation of a suspected case of child abuse or neglect by a children's advocacy center, hospital, or clinic shall be confidential and shall not be released or otherwise made available except:

(1) To the attorney representing the abused child in a custody or juvenile case with an order of appointment or an order recognizing entry of appearance;

(2) For any audit or similar activity conducted with the administration of any plan or program by any governmental agency which is authorized by law to conduct the audit or activity;

(3) To law enforcement agencies, a prosecuting attorney, or the Attorney General;

(4) To any licensing or registering authority to the extent necessary to carry out its official responsibilities, but the information shall be maintained as confidential;

(5) To a grand jury or court upon a finding that:

(A) Information in the record is necessary for the determination of a civil, criminal, or administrative issue before the court or grand jury; and

(B) The information cannot be obtained from a person or entity described in subdivision (b)(2) of this section;

(6) To the Department of Human Services;

(7) To a court-appointed special advocate volunteer with a valid court order;

(8) Images of a child's breast, genitals, or anus shall not be released except as provided under subsection (c) of this section;

(9) All records may be released to an attorney in any criminal, civil, or administrative proceeding or to a party in a criminal, civil, or administrative proceeding if the party is not represented by an attorney as permitted under criminal, civil, or administrative discovery rules upon a finding by the court that:

(A) Information in the record is necessary for the determination of a criminal, civil, or administrative issue before a court or grand jury; and

(B) The information cannot be obtained from a person or entity described in subdivision (b)(2) of this section; and

(10) Medical records may be released to a person providing medical or psychiatric care or services to the abused child.

(b)(1) Except as provided in subdivision (b)(2) of this section, no person or agency to whom disclosure is made may disclose to any other person reports or other information obtained under this section.

(2) Law enforcement agencies, a prosecuting attorney, the department, a court of competent jurisdiction, or the Attorney General may release reports or information obtained under this section. However, any report or information released under this subsection shall remain confidential.

(c)(1) Nothing in this section shall deny or diminish the right of an attorney for a party or a party to a criminal, civil, or administrative proceeding to receive discovery as provided in this section in order for the attorney or party to:

(A) Prepare for trial;

(B) File appropriate pleadings; or

(C) Present evidence in court.

(2)(A) The circuit court shall issue protective orders under the Arkansas Rules of Criminal Procedure or Arkansas Rules of Civil Procedure, as applicable, to ensure that those items of evidence for which there is a reasonable expectation of privacy are not distributed to persons or institutions without a legitimate interest in the evidence and otherwise should be sealed. There is a reasonable expectation of privacy in the following items:

(i) Audio or videotapes of a child witness;

(ii) Photographs of a child witness;

(iii) Name of a child victim;

(iv) Medical records of a child victim; and



(v) Images of a child's breast, genitals, or anus.

(B) The administrative hearing officer or administrative law judge shall issue protective orders to ensure that those items of evidence for which there is a reasonable expectation of privacy are not distributed to persons or institutions without a legitimate interest in the evidence and that otherwise should be sealed. There is a reasonable expectation of privacy in the following items:

(i) Audio or videotapes of a child witness;

(ii) Photographs of a child witness;

(iii) Name of a child victim;

(iv) Medical records of a child victim; and

(v) Images of a child's breast, genitals, or anus.

(C)(i) The circuit court may enforce the orders with criminal or civil contempt or sanctions, as appropriate.

(ii) The circuit court may modify or vacate a protective order for good cause.

(iii) If a protective order was entered and has not been vacated, the remedy for a violation of the protective order is limited to criminal or civil contempt or sanctions by the circuit court in which the protective order was entered.

(d) Except for purposes of enforcement concerning violations of a protective order under subsection (c) of this section, disclosure of information in violation of this section is a Class A misdemeanor.

**History.** Acts 2005, No. 1764, § 1; 2009, No. 1366, § 1; 2011, No. 1126, §§ 1, 2; 2013, No. 1174, § 1.

**Amendments.** The 2009 amendment inserted "by the court" in the introductory language of (a)(8); added the last sentence in (b)(2); rewrote (c); and deleted (d).

The 2011 amendment added (c)(2)(C)(iii) and (d).

The 2013 amendment, in the section heading, substituted "from" for "of" and added "hospitals, or clinics during an investigation of suspected cases of child

abuse or neglect" at the end; substituted "during an investigation of a suspected case of child abuse or neglect by a children's advocacy center, hospital, or clinic" for "centers performing the services described in § 20-78-105" in (a); in (a)(1), substituted "To" for "Medical records may be released to" and added "with an order of appointment or an order recognizing entry of appearance"; added present (a)(8) and redesignated former (a)(8) and (a)(9) as present (a)(9) and (a)(10); and added (c)(2)(A)(v), and (c)(2)(B)(v).

## **20-78-107. Criminal background checks for employees of private businesses that provide short-term child care for patrons.**

(a) A private business that provides short-term child care for its patrons shall perform a criminal history check with the Department of Arkansas State Police and a Child Maltreatment Central Registry check with the Department of Human Services for every employee that is employed in a capacity that directly or indirectly relates to providing care or supervision of any child.

(b) Employees who have pleaded guilty or nolo contendere to or have been found guilty of an offense for which registration under the Sex Offender Registration Act of 1997, § 12-12-901 et seq., is required shall

be prohibited from having any direct or indirect contact with or performing duties that directly or indirectly relate to providing care or supervision of a child who is in short-term child care provided by the private business for its patrons.

(c) As used in this section, “short-term child care” means that:

(1) The child does not receive care for more than:

(A) Five (5) hours per day; or

(B) Ten (10) hours per week;

(2) A parent or guardian is on the premises or is otherwise easily accessible; and

(3) The facility cares for five (5) children or less at one (1) time.

**History.** Acts 2011, No. 1181, § 1.

SUBCHAPTER 2 — LICENSING OF FACILITIES

SECTION.

20-78-203. Penalties.

20-78-205. Division of Child Care and Early Childhood Education.

20-78-206. Division of Child Care and Early Childhood Education — Rules and regulations.

20-78-219. Fines and penalties — Disposition of funds.

SECTION.

20-78-220. Persons or facilities abusing juveniles in their custody.

20-78-225. Child safety alarm devices.

20-78-226. Violation.

20-78-227. General liability insurance coverage required.

20-78-228. Child care facility floor plan on file with the emergency management coordinator.

**Effective Dates.** Acts 2003, No. 999, § 4 [5]: Apr. 1, 2003. Emergency clause provided: “It is found and determined by the General Assembly of the State of Arkansas that the federal District Courts for the Eastern and Western Districts of Arkansas have held the state’s school immunization statute to be unconstitutional, that the courts have stayed the effect of the finding, that if the stay is lifted before this act becomes effective, some students will be excluded from school attendance. Therefore, an emergency is declared to exist and this act being immediately necessary for the preservation of the public peace, health, and safety shall become effective on: (1) The date of its approval by the Governor; (2) If the bill is neither approved nor vetoed by the Governor, the expiration of the period of time during which the Governor may veto the bill; or (3) If the bill is vetoed by the Governor and the veto is overridden, the date the last house overrides the veto.”

Acts 2005, No. 1979, § 5: Apr. 11, 2005. Emergency clause provided: “It is found and determined by the General Assembly of the State of Arkansas that child safety alarm devices need to be installed in vehicles used to transport more than seven (7) passengers and one (1) driver, for programs licensed by the Department of Human Services in order to protect and preserve their health and safety. Therefore, an emergency is declared to exist and this act being immediately necessary for the preservation of the public peace, health, and safety shall become effective on: (1) The date of its approval by the Governor; (2) If the bill is neither approved nor vetoed by the Governor, the expiration of the period of time during which the Governor may veto the bill; or (3) If the bill is vetoed by the Governor and the veto is overridden, the date the last house overrides the veto.”

Acts 2009, No. 762, § 12, provided: “This act shall be effective September 1, 2009.”



Acts 2009, No. 778, § 4: Apr. 3, 2009. Emergency clause provided: "It is found and determined by the General Assembly of the State of Arkansas that the transportation of children is an integral part of child care services and subjects the children to a risk of injury which can be minimalized and insured against; and that this act is immediately necessary to provide protection to children served by various child care centers. Therefore, an

emergency is declared to exist and this act being immediately necessary for the preservation of the public peace, health, and safety shall become effective on: (1) The date of its approval by the Governor; (2) If the bill is neither approved nor vetoed by the Governor, the expiration of the period of time during which the Governor may veto the bill; or (3) If the bill is vetoed by the Governor and the veto is overridden, the date the last house overrides the veto."

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## 20-78-203. Penalties.

(a)(1) Any person violating any provisions of this subchapter and any person assisting any partnership, group, corporation, organization, or association in violating any provisions of this subchapter shall be guilty of a violation and upon conviction shall be fined in any sum not less than twenty-five dollars (\$25.00) and not more than one hundred dollars (\$100).

(2) Each day of the violation shall constitute a separate offense.

(b)(1) The Division of Child Care and Early Childhood Education of the Department of Human Services is authorized to impose monetary fines as civil penalties to be paid for failure to comply with the provisions of this subchapter or the regulations promulgated pursuant thereto.

(2) In determining whether a civil penalty is to be imposed, the following factors shall be considered by the division:

(A) The gravity of the violation, including the probability that death or serious physical harm to a child will result or has resulted, the severity and scope of the actual or potential harm, and the extent to which the provisions of the applicable statutes or regulations were violated;

(B)(i) The exercise of good faith.

(ii) Indications of good faith include, but are not limited to, awareness of the applicable statutes and regulations and reasonable diligence in securing compliance, prior accomplishments manifesting the desire to comply with the requirements, efforts to correct, and any other mitigating factors in favor of the operator;

(C) Any relevant previous violations committed; and

(D) The financial benefit of committing or continuing the violation.

(c) Prior to the imposition of monetary fines, the division shall provide notice and an opportunity to be heard before the Child Care Appeal Review Panel in accordance with hearing procedures in effect for the revocation or suspension of licenses.

(d) With the review and approval of the Arkansas Early Childhood Commission, the division shall publish and promulgate rules and regulations classifying violations as follows:

(1)(A)(i) Class A violations involve essential standards that must be met for substantial compliance to licensing requirements.

(ii) These standards address fire, health, safety, nutrition, staff-to-child ratio, and space.

(B)(i) Operation of an unlicensed child care facility shall be considered a Class A violation.

(ii) However, the definition of unlicensed child care facility shall not be interpreted to include exempt child care facilities as defined in § 20-78-209.

(C) Class A violations are subject to a civil penalty of one hundred dollars (\$100) for each violation; and

(2)(A) Class B violations involve administrative standards and standards that do not directly threaten the immediate health, safety, or welfare of the children.

(B) Class B violations are subject to a civil penalty of fifty dollars (\$50.00) for each violation.

(e)(1) Each day of occurrence of a Class A or Class B violation shall constitute a separate violation.

(2) Aggregate fines assessed for violation in any one (1) month shall not exceed five hundred dollars (\$500) for Class A violations or two hundred fifty dollars (\$250) for Class B violations.

(f)(1) When a facility has been found by the division to have committed Class A or Class B violations, then upon final administrative determination by the panel, notice shall be posted in the facility stating the violations found by the division to have occurred and the current status of the license.

(2) This notice shall be posted in the facility in a conspicuous place clearly visible to all staff, to all other individuals in the facility, and to all visitors to the facility.

(g)(1) Failure to post a proper notice as required by this section shall be considered to be a Class B violation for which civil penalties may be imposed as authorized by this section.

(2) Each day of noncompliance shall constitute a separate offense.

**History.** Acts 1969, No. 434, § 14; § 2; 1999, No. 1222, § 7; 2005, No. 1994, A.S.A. 1947, § 83-914; Acts 1987, No. 856, § 140.  
§ 1; 1991, No. 888, § 1; 1997, No. 1132,

## **20-78-205. Division of Child Care and Early Childhood Education.**

(a)(1) There is created the Division of Child Care and Early Childhood Education within the Department of Human Services. In creating the division, the General Assembly intends for the following to be maintained and enhanced:

(A) Coordination of existing early childhood education and child care programs;

(B) Placement of children in quality early childhood programs which support their development and readiness for school;



(C) Development of new child care services under welfare reform which promote the developmental needs of children receiving transitional employment assistance benefits or other forms of public assistance;

(D) Quality program standards for all early childhood and child care programs;

(E) State support for early childhood and child care programs to attain quality program standards;

(F) Economic and cultural integration of children in early childhood programs;

(G) Access to additional support services for early childhood and child care programs, such as health care and nutrition services;

(H) Career development opportunities for early childhood program staff;

(I) On-going interagency planning and collaboration in regard to early childhood and child care;

(J) Parent support and education in choosing appropriate early childhood programs for their children; and

(K) State support for local leadership, program innovation, and excellence in early childhood and care programs.

(b) The division shall have the following duties:

(1) Administration of the Child Care and Development Block Grant and other child care funds, state and federal, that are available to the Department of Human Services;

(2) Administration of Arkansas Better Chance Program, under interagency agreement with the Department of Education;

(3) Administration of the Arkansas Special Nutrition Program;

(4) Establishment and promulgation of rules to be approved by the Arkansas Early Childhood Commission setting standards governing the granting, revocation, refusal, and suspension of licenses for a child care facility and the operation of child care facilities in this state, as defined by § 20-78-202;

(5) Staff support for the operation of the commission;

(6) Provide consultative resources for the private sector in developing child care programs;

(7) Provide consultative resources for the private sector in developing child care facilities;

(8) Solicit grant funds for exemplary early childhood and child care programs; and

(9) Administration of the birth through prekindergarten teaching credential and the promulgation of rules to implement the teaching credential program under § 20-78-801 et seq.

(c)(1) In addition to any other rights, powers, functions, and duties granted by law to the division, the Department of Human Services is hereby authorized to promote and cooperate in the establishment of a foundation under the Arkansas nonprofit corporation law and to accept support and assistance in the form of money, property, or otherwise from the foundation to be used to enhance quality, affordability, and

availability of child care and early education for all children in the state.

(2) If a foundation is established for the early care and education of children and if the Department of Human Services shares resources or facilities with the foundation or accepts support and assistance from the foundation, the foundation shall file annually a report with the Governor, the Legislative Council, and the Legislative Joint Auditing Committee showing the amount and source of all gifts, grants, and donations of money or property received by the foundation and all expenditures or other dispositions of money or property by the foundation during the preceding year.

(3) After consultation with the commission, the Director of the Division of Child Care and Early Childhood Education shall prepare rules for the use of foundation funds. The director shall submit the proposed rules to the Legislative Council for its review.

(4) No person over whom the Department of Human Services has day-to-day managerial control shall receive compensation or remuneration from funds not in the State Treasury.

**History.** Acts 1969, No. 434, § 12; 1973, No. 123, § 2; 1979, No. 904, § 1; A.S.A. 1947, § 83-911; Acts 1987, No. 856, § 1; 1989, No. 400, §§ 1, 2; 1995, No. 1280, §§ 13, 14; 1997, No. 250, § 205; 1997, No. 1132, § 4; 1999, No. 1222, § 9; 2001, No. 1271, § 1; 2009, No. 187, § 2; 2011, No. 1121, § 15.

**Amendments.** The 2009 amendment deleted “and regulations” following “rules” in (b)(4), added (b)(9), and made related and minor stylistic changes.

The 2011 amendment deleted former (c) and redesignated (d) as present (c).

## **20-78-206. Division of Child Care and Early Childhood Education — Rules and regulations.**

(a)(1)(A) The Division of Child Care and Early Childhood Education of the Department of Human Services, with the approval of the Arkansas Early Childhood Commission, shall promulgate and publish rules and regulations setting minimum standards governing the granting, revocation, refusal, and suspension of licenses for a child care facility and the operation of a child care facility.

(B) In developing proposed rules and regulations, the division shall consult with the Director of the Department of Health or his or her designated representative in regard to rules and regulations relating to health.

(C) The commission shall review and approve proposed rules and regulations promulgated by the division.

(2)(A)(i) However, no child care facility shall continue to admit a child who has not been age-appropriately immunized from poliomyelitis, diphtheria, tetanus, pertussis, red (rubeola) measles, rubella, and any other diseases as designated by the State Board of Health within fifteen (15) program days after the child’s original admission.

(ii) The immunization shall be evidenced by a certificate of a licensed physician or a public health department acknowledging the



immunization. The division shall consult with the Commissioner of Education or his or her designated representative in regard to rules and regulations relating to education.

(B)(i) The provisions of subdivision (a)(2)(A) of this section pertaining to immunizations shall not apply if the parents or legal guardian of that child object thereto on the grounds that immunization conflicts with the religious or philosophical beliefs of the parent or guardian.

(ii) The parents or legal guardian of the child shall complete an annual application process developed in the rules and regulations of the Department of Health for medical, religious, and philosophical exemptions.

(iii) The rules and regulations developed by the Department of Health for medical, religious, and philosophical exemptions shall include, but not be limited to:

(a) A notarized statement requesting a religious, philosophical, or medical exemption from the Department of Health by the parents or legal guardian of the child regarding the objection;

(b) Completion of an educational component developed by the Department of Health that includes information on the risks and benefits of vaccination;

(c) An informed consent from the parents or guardian that shall include a signed statement of refusal to vaccinate based on the Department of Health's refusal-to-vaccinate form; and

(d) A signed statement of understanding that:

(1) At the discretion of the Department of Health, the unimmunized child or individual may be removed from day care or school during an outbreak if the child or individual is not fully vaccinated; and

(2) The child or individual shall not return to school until the outbreak has been resolved and the Department of Health approves the return to school.

(iv) No exemptions may be granted under this subdivision (a)(2)(B) until the application process has been implemented by the Department of Health and completed by the applicant.

(v) Furthermore, the provisions of subdivision (a)(2)(A) of this section requiring pertussis vaccination shall not apply to any child with a sibling, either whole blood or half blood, who has had a serious adverse reaction to the pertussis antigen, which reaction resulted in a total permanent disability.

(3) The director and the commissioner and their designated representatives are directed to cooperate with and assist the division in developing rules and regulations in the respective areas of health and education.

(4) In developing these rules and regulations, the division shall consult with such other agencies, organizations, or individuals as it shall deem appropriate.

(5) Rules and regulations promulgated by the division pursuant to this section may be amended by the division from time to time provided

that any amendment to the rules and regulations shall be published and furnished to all licensed child care facilities and to all applicants for a license approved by the commission at least sixty (60) days prior to the effective date of the amendment.

(b) In establishing requirements and standards for the granting, revocation, refusal, and suspension of a license for a child care facility, the division shall adopt such rules and regulations as will:

(1) Promote the health, safety, and welfare of children attending a child care facility;

(2) Promote safe, comfortable, and healthy physical facilities for the children who attend the child care facility;

(3) Ensure adequate supervision of the children by capable, qualified, and healthy individuals;

(4) Ensure appropriate educational programs and activities; and

(5) Ensure adequate and healthy food service where food service is offered by the child care facility.

(c)(1) Questions between providers and the division concerning substantial compliance with the published standards, founded licensing complaints, denials of alternative compliance requests, and adverse actions shall first be appealed through the division's internal appeal process and then may be appealed through the Child Care Appeal Review Panel for determination.

(2) The division shall follow the procedures prescribed for adjudication in the Arkansas Administrative Procedure Act, § 25-15-201 et seq., in exercising any power authorized by § 20-78-213.

(d) If, upon the filing of a petition for a judicial review, the reviewing court enters a stay prohibiting enforcement of a decision of the division, the court shall complete its review of the record and announce its decision within one hundred twenty (120) days of the entry of the stay. If the court does not issue its findings within one hundred twenty (120) days of the issuance of the stay, the stay shall be considered vacated.

(e) All rules and regulations promulgated pursuant to this section shall be reviewed by the Senate Interim Committee on Children and Youth or an appropriate subcommittee thereof and the Subcommittee on Children and Youth of the House Committee on Aging, Children and Youth, Legislative and Military Affairs.

(f)(1) Any person with reasonable cause to suspect that a child care facility has violated any provision of this subchapter or any rule or regulation of the division may immediately notify the Department of Human Services.

(2) The Department of Human Services shall not release data that would identify the person who made the report or who cooperated in a subsequent investigation of a child care facility unless a court of competent jurisdiction orders the release of information for good cause shown.

(3) Following the inspection and investigation of a child care facility as provided under this subsection (f), the Department of Human Services shall, upon request, provide information to the person or



agency reporting the suspected violation as to whether an investigation has been conducted.

(4) Willfully making false notification pursuant to this subsection (f) shall be a Class C misdemeanor.

**History.** Acts 1969, No. 434, § 4; 1977, No. 1280, § 15; 1997, No. 312, § 17; 1997, No. 349, § 2; A.S.A. 1947, §§ 83-904, 83-911.1; Acts 1991, No. 888, §§ 2, 4; 1995, No. 870, § 1; 1997, No. 1132, § 5; 1999, No. 1222, § 10; 2003, No. 999, § 3.

### RESEARCH REFERENCES

**U. Ark. Little Rock L. Rev.** Survey of Requirements, 26 U. Ark. Little Rock L. Legislation, 2003 Arkansas General Assembly, Education Law, Immunization Rev. 384.

## 20-78-219. Fines and penalties — Disposition of funds.

(a) If any licensee fails to pay any monetary fine imposed as a civil penalty within sixty (60) days of the Division of Child Care and Early Childhood Education's decision imposing the penalty, the amount of the fine shall be considered to be a debt owed the State of Arkansas and may be collected by civil action.

(b)(1) All fines and penalties collected under the provisions of this subchapter shall be special revenues to be deposited in the State Treasury to the credit of a special fund to be known as the Child Care Fund, to be used by the division to meet the costs of conducting the statewide criminal records checks required under § 20-78-606 or to provide grants to child care facilities for enhancement of the facility or for training of personnel in child care facilities under the direction of the division.

(2) Subject to those rules and regulations as may be implemented by the Chief Fiscal Officer of the State, the disbursing officer for the Department of Human Services is authorized to transfer all unexpended funds relative to the fines and penalties collected from child care facilities as certified by the Chief Fiscal Officer of the State, to be carried forward and made available for expenditures for the same purpose for any following fiscal year.

**History.** Acts 1987, No. 856, § 1; 1997, No. 1132, § 18; 2009, No. 762, § 9.

**Amendments.** The 2009 amendment substituted “§ 20-78-606” for “§ 20-78-602” in (b)(1).

**Effective Dates.** Acts 2009, No. 762, § 12, provided: “This act shall be effective September 1, 2009.”

## 20-78-220. Persons or facilities abusing juveniles in their custody.

(a) If a juvenile is found to be abused or neglected due to the acts or omissions of a person other than the parent or guardian of the juvenile, the court may enter an order restraining or enjoining the person or facility employing that person from providing care, training, education,

or supervision of juveniles of whom the person or facility is not the parent or guardian.

(b) If the person or facility restrained or enjoined was not subject to this subchapter, the court may order the person or facility to obtain a license from the Division of Child Care and Early Childhood Education as a condition precedent to the person or facility providing care, training, education, or supervision of any juveniles of which the person or facility is not the parent or guardian. If the court so orders, this subchapter shall thereafter apply to the persons or facility subject to the court order.

(c)(1) Information pertaining to child maltreatment is confidential under the Child Maltreatment Act, § 12-18-101 et seq.

(2) The division may receive information from any investigative agency on child maltreatment cases conducted within a child care facility and relative to licensure under this subchapter, including specific allegations, a factual description of the investigative findings, and the investigative determination.

(3) The division shall accept the investigative determinations of the appropriate investigative agencies for consideration in any action on child care facility licenses.

**History.** Acts 1987, No. 745, § 1; 1995, No. 1280, § 16; 1997, No. 1132, § 19; 2009, No. 758, § 28.

**A.C.R.C. Notes.** The contingency in Acts 2009, No. 758, § 29, was met by Acts 2009, No. 749.

**Amendments.** The 2009 amendment substituted "the Child Maltreatment Act, § 12-18-101 et seq." for "§ 12-12-506 "in (c)(1).

**Effective Dates.** Acts 2009, No. 758, § 29, provided: "Contingent Effectiveness. This act shall not become effective unless an act of the Eighty-Seventh General Assembly repealing the Arkansas Child Maltreatment Act, § 12-12-501 et seq., and enacting a new Child Maltreatment Act, § 12-18-101 et seq., becomes effective."

## **20-78-225. Child safety alarm devices.**

(a) All agencies or child care facilities licensed by the Department of Human Services under this subchapter, § 9-28-401 et seq., or § 20-78-201 et seq. that transport children shall have approved child safety alarm devices installed on any vehicles designed or used to transport more than seven (7) passengers and one (1) driver.

(b)(1) All such vehicles in active child transportation service prior to July 1, 2005, shall have a child safety alarm device installed by a qualified technician or mechanic no later than December 31, 2005.

(2) On or after July 1, 2005, each newly acquired vehicle placed in child transportation service shall have a child safety alarm installed before placing the vehicle into service.

(3) Any agencies or child care facilities required to have approved child safety alarm devices installed in a vehicle shall ensure that the devices are maintained and are in proper working order any time that the vehicle is in use for transporting children.

(c) The department shall:

(1) Maintain a list of approved child safety alarm devices; and



(2) Promulgate rules as necessary for the proper implementation of this section.

(d) Contingent upon the availability of funding for this purpose, the department may provide reimbursement to agencies or child care facilities required under this section to retrofit vehicles in service prior to July 1, 2005, but the requirement to have approved child safety alarm devices in vehicles as required under this section shall not be contingent on the availability of funding or upon an agency's or a child care facility's eligibility for reimbursement.

**History.** Acts 2005, No. 1979, § 3.

### **20-78-226. Violation.**

(a) It shall be unlawful to transport children in a vehicle that is required to have an approved child safety alarm device as provided under § 20-78-225 if the approved child safety alarm device:

- (1) Has not been installed;
- (2) Is not in proper working condition; or
- (3) Has been disconnected.

(b) Any person who knowingly violates the provisions of this section shall be guilty of a Class A misdemeanor.

**History.** Acts 2005, No. 1979, § 4.

### **20-78-227. General liability insurance coverage required.**

(a) The purpose of this section is to enhance safe and responsible passenger transportation of children in child care by requiring appropriate liability insurance and driver training.

(b) The Division of Child Care and Early Childhood Education of the Department of Human Services is directed, in collaboration with the State Insurance Department, to develop and promulgate rules requiring sufficient and appropriate minimum levels of general liability insurance coverage for licensed child care centers and licensed and registered child care family homes, including coverage for transportation services when applicable.

(c) The division shall promulgate rules requiring all drivers of vehicles transporting children on behalf of licensed child care centers and licensed and registered child care family homes to complete a comprehensive program of driver safety training.

**History.** Acts 2009, No. 778, §§ 1, 2.

**A.C.R.C. Notes.** Acts 2009, No. 778, § 3, provided: "The rules that require li-

ability insurance and driver safety training shall be in effect no later than December 31, 2009."

### **20-78-228. Child care facility floor plan on file with the emergency management coordinator.**

(a)(1) As used in this section, "floor plan" means a document containing:

- (A) A schematic drawing of facilities and property used by the child care facility, including the configuration of rooms, spaces, and other physical features of buildings;
  - (B) The location or locations where children enrolled in child care spend time regularly;
  - (C) The escape routes approved by the local fire department for the child care facility or facilities;
  - (D) The ages of children served by the child care facility;
  - (E) The licensed capacity of children enrolled in the child care facility; and
  - (F) The contact information for at least two (2) emergency contacts for the child care facility.
- (2) An aerial view of the child care facility and property used by the child care facility shall be included with the floor plan if available.
- (b) No later than January 1, 2014, a child care facility licensed by the Division of Child Care and Early Childhood Education of the Department of Human Services under this subchapter, the Child Welfare Agency Licensing Act, § 9-28-401 et seq., or the Child Care Facility Licensing Act, § 20-78-201 et seq., shall file a copy of the child care facility’s floor plan with the emergency management coordinator for the local office of emergency management or the interjurisdictional office of emergency management that serves the area where the child care facility is located within:
- (1) Thirty (30) days of receiving a license; and
  - (2) Thirty (30) days of a change or modification to the floor plan.
- (c) The emergency management coordinator shall ensure that the child care facility’s floor plan submitted under subsection (b) of this section is available at the 911 public safety communications center and the local office of emergency management or the interjurisdictional office of emergency management that serves the area where the child care facility is located.
- (d) The Department of Human Services shall adopt rules as necessary to implement this section.

**History.** Acts 2013, No. 1159, § 2.

**SUBCHAPTER 5 — EARLY CHILDHOOD COMMISSION**

SECTION.	ties Loan Guarantee Trust
20-78-501. Creation — Composition — Meetings.	Fund.
20-78-503. Arkansas Child Care Facili-	

**20-78-501. Creation — Composition — Meetings.**

- (a)(1) There is hereby established the Arkansas Early Childhood Commission, to be composed of twenty-five (25) members.
- (2) The chair of the commission shall be selected annually by majority vote of the commission.



(b) The following members of the commission shall be appointed by the Governor, subject to confirmation by the Senate:

(1) Three (3) members affiliated with child care provider agencies, organizations, or programs, of which one (1) of the members shall be affiliated with a family child care home;

(2) One (1) member affiliated with the Arkansas Head Start State Collaboration Office;

(3) One (1) member affiliated with a Head Start program;

(4) One (1) member affiliated with an Early Head Start program;

(5) One (1) member affiliated with a Migrant/Seasonal Head Start program;

(6) One (1) member affiliated with a Home Instruction for Parents of Preschool Youngsters;

(7) One (1) member employed as an administrator by a public school district;

(8) One (1) member employed by a public school district as a teacher with early childhood responsibilities;

(9) One (1) member trained as an early childhood education professional;

(10) One (1) member who is a parent of a child who attends a child care program;

(11) Two (2) members representing the business community who have an interest in early childhood education;

(12) One (1) member representing the Arkansas Chapter of the American Academy of Pediatrics;

(13) One (1) member representing the Arkansas Chapter of the American Academy of Family Physicians;

(14) One (1) member who is a clinical provider of childhood behavioral and mental health services specializing in prevention and early intervention; and

(15) One (1) member representing the Arkansas Association of Colleges for Teacher Education, Council of Deans.

(c) The members identified in subsection (b) of this section shall serve three-year terms, and the terms shall begin on July 1.

(d) The remaining membership shall consist of:

(1) The chair of the Subcommittee on Children and Youth of the House Committee on Aging, Children and Youth, Legislative and Military Affairs or his or her designee;

(2) The chair of the Senate Interim Committee on Children and Youth or his or her designee;

(3) The chair of the House Committee on Education or his or her designee;

(4) The chair of the Senate Committee on Education or his or her designee;

(5) The Commissioner of Education or his or her designee;

(6) The Director of the Department of Health or his or her designee; and

(7) The Director of the Department of Career Education or his or her designee.

(e)(1) The commission shall meet at least quarterly and at such other times as may be deemed necessary for the performance of the duties of the commission.

(2) Special meetings of the commission may be called by the chair or by agreement of a majority of the members of the commission.

(f)(1) The members of the commission shall serve without compensation or per diem but shall be entitled to reimbursement for actual expenses incurred in the performance of duties as members of the commission. Expense reimbursement shall be in accordance with state travel and official business expense reimbursement procedures and regulations.

(2) Expense reimbursement shall be paid from funds appropriated to the Division of Child Care and Early Childhood Education for this purpose.

(g) The commission shall report annually to the House Committee on Education and the Senate Committee on Education as set out in § 20-78-502.

**History.** Acts 1989, No. 202, § 1; 1997, No. 250, § 207; 1997 No. 1132, § 24; 1999, No. 324, § 1; 1999, No. 1560, § 1; 2001, No. 1288, § 18; 2009, No. 28, § 2; 2011, No. 1121, § 16; 2013, No. 403, § 2.

**Amendments.** The 2009 amendment substituted "twenty-four (24)" for "eighteen (18)" in (a)(1); and rewrote (b) and (d).

The 2011 amendment inserted "of which" in (b)(1).

The 2013 amendment substituted "twenty-five (25) members" for "twenty-four (24) members" in (a)(1); and added (b)(15).

### **20-78-503. Arkansas Child Care Facilities Loan Guarantee Trust Fund.**

(a) There is established a cash fund account of the Division of Child Care and Early Childhood Education to be known as the Arkansas Child Care Facilities Loan Guarantee Trust Fund. This cash fund account is to be maintained in one (1) or more financial institutions of the state and shall be administered in accordance with this subchapter.

(b) The division is hereby authorized to accept moneys for the fund from any source, including, but not limited to, allocations from the Treasurer of State as provided in § 20-78-504.

(c) The fund shall be a continuing fund, not subject to fiscal year limitations, and shall be used to guarantee loans for the expansion or development of child care facilities in this state and as provided in subsection (d) of this section.

(d) Any interest at the end of the fiscal year which exceeds the amount necessary to cover loan defaults occurring during that fiscal year shall be made available for professional development and quality improvement activities and grants, including without limitation to support an early childhood foundation or public-private partnership.



(e) This fund shall be administered by the division with technical assistance from the Arkansas Early Childhood Commission and the Arkansas Development Finance Authority.

**History.** Acts 1989, No. 202, § 1; 1997, No. 540, § 43; 1997, No. 1132, § 26; 2001, No. 305, § 1; 2011, No. 636, § 1.  
**Amendments.** The 2011 amendment added “including without limitation to support an early childhood foundation or public-private partnership” at the end of (d).

SUBCHAPTER 6 — BACKGROUND CHECKS OF CHILD CARE FACILITY  
LICENSEES AND EMPLOYEES

SECTION.	SECTION.
20-78-601, 20-78-602. [Repealed.]	20-78-606. Criminal history records
20-78-604, 20-78-605. [Repealed.]	checks required.

**Effective Dates.** Acts 2009, No. 762, § 12, provided: “This act shall be effective September 1, 2009.”

20-78-601, 20-78-602. [Repealed.]

**Publisher’s Notes.** These sections, concerning child abuse central registry check and criminal records check, were repealed by Acts 2009, No. 762, § 10. They were derived from the following sources:

20-78-601. Acts 1993, No. 1293, § 1; 1995, No. 1280, § 7; 1997, No. 1132, § 30; 1997, No. 1198, § 1.

20-78-602. Acts 1993, No. 1293, §§ 2, 3; 1995, No. 1280, § 8; 1997, No. 1132, § 31; 1997, No. 1198, § 2; 1999, No. 1222, §§ 14, 15.

**Effective Dates.** Acts 2009, No. 762, § 12, provided: “This act shall be effective September 1, 2009.”

20-78-604, 20-78-605. [Repealed.]

**Publisher’s Notes.** These sections, concerning qualifications for child care ownership, operation, or employment and definitions for volunteers’ records check, were repealed by Acts 2009, No. 762, § 10. They were derived from the following sources:

20-78-604. Acts 1993, No. 1293, § 5; 1995, No. 1280, § 10; 1997, No. 1132, § 32; 1997, No. 1198, § 3; 2003, No. 1087, § 21; 2003, No. 1378, § 1.

20-78-605. Acts 1995, No. 1280, § 11; 1997, No. 1198, § 4.

**Effective Dates.** Acts 2009, No. 762, § 12, provided: “This act shall be effective September 1, 2009.”

20-78-606. Criminal history records checks required.

- (a) As used in this section:
- (1) “Registry records check” means the review of one (1) or more database systems maintained by a state agency that contain information relative to a person’s suitability for licensure or certification as a

service provider or employment with a service provider to provide care as that term is defined in § 20-38-101; and

(2) “Service provider” means any of the following:

(A) A child care facility as defined by § 20-78-202; and

(B) A church-exempt child care facility as recognized under § 20-78-209.

(b) Beginning September 1, 2009, a service provider is subject to the requirements of this section and § 20-38-101 et seq. concerning criminal history records checks.

(c)(1) A person offered employment with a service provider on or after September 1, 2009, is subject to the requirements of this section and § 20-38-101 et seq., concerning criminal history records checks.

(2)(A) A person who was offered employment by a service provider prior to September 1, 2009, was subject to a criminal history records check under §§ 20-78-601 — 20-78-605 [repealed], and has continued to be employed by the service provider who initiated the criminal history records check may continue employment with the service provider based on the results of the criminal history records check process conducted under §§ 20-78-601 — 20-78-605 [repealed].

(B) When the person next undergoes a periodic criminal history records check, the person’s continued employment with the service provider is contingent on the results of a criminal history records check under § 20-38-101 et seq.

(d)(1) The person who signs an application for licensure or certification as a service provider on or after September 1, 2009, is subject to the requirements of this section and § 20-38-101 et seq., concerning criminal history records checks.

(2)(A) The person who signed an application for licensure or certification of a service provider prior to September 1, 2009, was subject to a criminal history records check under §§ 20-78-601 — 20-78-605 [repealed], and has continued to maintain the licensure or certification of the service provider may continue to maintain the licensure or certification of the service provider based on the results of the criminal history records check process conducted under §§ 20-78-601 — 20-78-605 [repealed].

(B) When the service provider next undergoes a periodic criminal history records check, the service provider’s continued licensure or certification is contingent on the results of a criminal history records check under § 20-38-101 et seq.

(e) The Division of Child Care and Early Childhood Education of the Department of Human Services shall establish by rule requirements for registry records checks for:

(1) An applicant for licensure or exemption from licensure as a service provider;

(2) An applicant for employment with a service provider; and

(3) An employee of a service provider.

(f) The division shall establish by rule requirements for criminal history and registry records checks of persons who volunteer for a service provider.



**History.** Acts 2009, No. 762, § 11.

§ 12, provided: "This act shall be effective September 1, 2009."

**Effective Dates.** Acts 2009, No. 762,

## SUBCHAPTER 8 — BIRTH THROUGH PREKINDERGARTEN TEACHING CREDENTIAL AND ENDORSEMENT

### SECTION.

20-78-801. Credential and endorsement.

20-78-802. Minimum requirements for a teaching credential.

### SECTION.

20-78-803. Professional development.

20-78-804. Monitoring and assessment.

20-78-805. Core courses.

**A.C.R.C. Notes.** Acts 2009, No. 187, § 1, provided: "The General Assembly finds that:

"(1) The State of Arkansas has long been a leader in the field of early childhood education;

"(2) This leadership includes providing an increasingly sophisticated array of professional development options for persons working with young children;

"(3) At present, there is no clear professional pathway for persons who wish to work primarily with children from birth through prekindergarten age;

"(4) While few positions currently require baccalaureate level courses for working with infants and toddlers, an early childhood teaching license is required for teaching public school classes in grades prekindergarten through four (P-4);

"(5) Although some professional development is available for Head Start and Early Head Start staff and for persons

who move through the Arkansas Early Childhood Professional Development System, a clear pathway should be created for those interested in pursuing professional development pathways that do not lead primarily to public school education;

"(6) An inclusive birth through prekindergarten teaching credential and an inclusive birth through prekindergarten endorsement to an Arkansas P-4 teaching license will provide recognized professional pathways that strengthen the existing infrastructure that supports very young children and their families;

"(7) National recommendations suggest that those who work with very young children need preparation specific to that age group; and

"(8) The birth through prekindergarten teaching credential and birth through prekindergarten endorsement program would specifically address the early care and education needs of children from birth through prekindergarten."

### 20-78-801. Credential and endorsement.

(a)(1) A person teaching in a public early childhood education program may obtain a birth through prekindergarten teaching credential from the Division of Child Care and Early Childhood Education.

(2) Subdivision (a)(1) of this section shall not be construed to permit a person teaching in a public early childhood education program to utilize the teaching credential in lieu of a P-4 teaching license issued by the State Board of Education when the license is required.

(b) As used in this subchapter, "public early childhood education program" means an education program that:

(1) All or part of which is funded with state or federal funds; and

(2) Serves children whose ages may range from birth through prekindergarten.

(c)(1) The division shall develop the teaching credential under this subchapter not later than January 31, 2010.

(2) The teaching credential is valid for five (5) years and may be renewed upon completion of the requirements set forth in law and established by the division.

(3) An applicant for an initial teaching credential or a renewal teaching credential is not required to pay a fee for submitting the application or obtaining the teaching credential.

(d) Institutions of higher education in this state may submit to the Department of Education proposals for the creation of a birth through prekindergarten endorsement for P-4 teacher licensure.

**History.** Acts 2009, No. 187, § 3.

### **20-78-802. Minimum requirements for a teaching credential.**

The Division of Child Care and Early Childhood Education shall develop a birth through prekindergarten teaching credential that requires without limitation that the applicant:

(1) Meet a minimum educational level; and

(2)(A) Complete a core of courses in early childhood development and early childhood education.

(B) The core courses shall meet the division's standards for the preparation of early childhood professionals.

**History.** Acts 2009, No. 187, § 3.

### **20-78-803. Professional development.**

A person holding a birth through prekindergarten teaching credential under this subchapter shall complete a minimum number of hours of professional development in early childhood development or early childhood education as determined by the Division of Child Care and Early Childhood Education.

**History.** Acts 2009, No. 187, § 3.

### **20-78-804. Monitoring and assessment.**

The Division of Child Care and Early Childhood Education shall periodically monitor and assess a person holding a birth through prekindergarten teaching credential as the division may determine by rule.

**History.** Acts 2009, No. 187, § 3.

### **20-78-805. Core courses.**

In consultation with the Division of Child Care and Early Childhood Education and the state-supported institutions of higher education in this state, the Arkansas Higher Education Coordinating Board shall



establish a minimum core of early childhood development and education courses that shall be applied toward meeting the requirements of the prekindergarten endorsement to a teaching degree.

**History.** Acts 2009, No. 187, § 3.

SUBCHAPTER 9 — HOME VISITATION

SECTION.

- 20-78-901. Definitions.
- 20-78-902. Home visitation programs — Oversight.
- 20-78-903. Evidence-based program — Promising programs.
- 20-78-904. Applicability.

SECTION.

- 20-78-905. Processes for oversight.
- 20-78-906. State agency contract and grants.
- 20-78-907. Outcomes measurement — Report.
- 20-78-908. Parental and guardian rights.

**Effective Dates.** Acts 2013, No. 528, § 4: Mar. 28, 2013. Emergency clause provided: “It is found and determined by the General Assembly of the State of Arkansas that the home visiting networks provide important services to Arkansas’s most vulnerable citizens, our infants and toddlers; that the agencies administering home visiting programs need to ensure the accountability of these programs; and that these changes need to be made immediately so that planning and coordination among the agencies comply in a

timely manner with the reporting requirements. Therefore, an emergency is declared to exist, and this act being immediately necessary for the preservation of the public peace, health, and safety shall become effective on: (1) The date of its approval by the Governor; (2) If the bill is neither approved nor vetoed by the Governor, the expiration of the period of time during which the Governor may veto the bill; or (3) If the bill is vetoed by the Governor and the veto is overridden, the date the last house overrides the veto.”

20-78-901. Definitions.

As used in this subchapter:

- (1) “Evidence-based program” means a program based on a clear, consistent model such as those identified by the Home Visiting Evidence of Effectiveness review authorized by the United States Department of Health and Human Services, including a program that:
  - (A) Demonstrates strong links to other community-based services;
  - (B) Employs well-trained and competent staff and provides continual professional development relevant to the specific program model being delivered;
  - (C) Follows a program manual or design that specifies the purpose, outcomes, duration, and frequency of service that constitute the program;
  - (D) Operates with fidelity to the model;
  - (E) Operates within an organization that ensures compliance with home visitation standards; and
  - (F) Provides research-based services grounded in relevant, empirically based knowledge;

(2) “Home visitation” means voluntary family-focused services that promote appropriate prenatal care to assure healthy births, primarily in the home, to an expectant parent or a parent with an infant, toddler, or child up to kindergarten entry that address:

- (A) Child development;
- (B) Literacy and school readiness;
- (C) Maternal and child health;
- (D) Positive parenting practices;
- (E) Resource and referral access; and
- (F) Safe home environments;

(3) “Home visiting program” means the infrastructure and programs that support and provide home visitation; and

(4) “Promising program” means a home visiting program that does not meet the criteria of evidenced-based programs but:

- (A) Demonstrates strong links to other community-based services;
- (B) Employs well-trained and competent staff and provides continual professional development relevant to the specific program model being delivered;
- (C) Follows a manual or design that specifies the program’s purpose, outcomes, duration, and frequency of service;
- (D) Has data or evidence demonstrating that the program is effective at achieving positive outcomes for pregnant women, infants, children, or their families;
- (E) Operates with fidelity to the program or model; and
- (F) Operates within an organization that ensures compliance with home visitation standards.

**History.** Acts 2013, No. 528, § 3.

## **20-78-902. Home visitation programs — Oversight.**

(a) A home visitation program under this subchapter shall provide face-to-face home visits by nurses, social workers, and other early childhood and health professionals or trained and supervised lay workers to:

- (1) Build healthy parent and child relationships;
- (2) Empower families to be self-sufficient;
- (3) Enhance social and emotional development;
- (4) Improve maternal, infant, or child health outcomes, including reducing preterm births;
- (5) Improve the health of the family;
- (6) Increase school readiness;
- (7) Promote positive parenting practices;
- (8) Support cognitive development of children; or
- (9) Reduce incidences of child maltreatment and injury.

(b) The State Child Abuse and Neglect Prevention Board, the Department of Health, and the Department of Human Services shall cooperate to ensure accountability of home visitation.



**History.** Acts 2013, No. 528, § 3.

### **20-78-903. Evidence-based program — Promising programs.**

The State Child Abuse and Neglect Prevention Board, the Department of Health, and the Department of Human Services shall cooperate to use at least ninety percent (90%) of state funds appropriated for home visitation to support home visitation programs that are:

(1) Evidence-based programs that:

(A) Are linked to program-determined outcomes and associated with a national organization, institution of higher education, or national or state public health institute;

(B) Have comprehensive home visitation standards that ensure high-quality service delivery and continuous quality improvement;

(C) Have demonstrated significant, sustained positive outcomes; and

(D) Demonstrate reliability through:

(i) Past evaluations using rigorous randomized controlled research designs, the results of which have been published in a peer-reviewed journal; or

(ii) A basis in quasi-experimental research using two (2) or more separate, comparable client samples; or

(2) Promising programs that have:

(A) An active evaluation of each promising program; or

(B)(i) A demonstration of a plan and timeline for an active evaluation of each promising program.

(ii) A timeline under subdivision (2)(B)(i) of this section shall include a projected time frame for transition from a promising program to an evidence-based program.

**History.** Acts 2013, No. 528, § 3.

### **20-78-904. Applicability.**

This subchapter does not apply to:

(1) A program that exclusively provides early intervention services under Part B or C of the Individuals with Disabilities Education Act, 20 U.S.C. §§ 1431 — 1444;

(2) A program that provides a one-time home visit or infrequent home visits, such as a home visit for a newborn child or a child in preschool; or

(3) A program that provides home visits under a physician's order or protocol and has a valid Class A and Class B home health care services agency license under § 20-10-801 et seq.

**History.** Acts 2013, No. 528, § 3.

**20-78-905. Processes for oversight.**

(a) The State Child Abuse and Neglect Prevention Board, the Department of Health, and the Department of Human Services shall cooperate to develop interrelated processes that provide for collaborating and sharing relevant home visiting program data and information.

(b) The processes for collaborating and sharing data may include without limitation:

(1) A uniform format for the collection of data relevant to each home visiting program model; and

(2) The development of common contract or grant language related to voluntary home visiting programs.

**History.** Acts 2013, No. 528, § 3.

**20-78-906. State agency contract and grants.**

A state agency that authorizes funds through payments, contracts, or grants that are used for home visitation shall include in its contract or funding agreement language regarding home visitation that is consistent with this subchapter.

**History.** Acts 2013, No. 528, § 3.

**20-78-907. Outcomes measurement — Report.**

(a) The State Child Abuse and Neglect Prevention Board, the Department of Health, the Department of Human Services, and providers of home visiting program services in consultation with one (1) or more research experts shall:

(1) Develop an outcomes measurement plan to monitor outcomes for children and families receiving services through state-funded home visiting programs;

(2) Develop indicators that measure each outcome area under § 20-78-902; and

(3) Create a report that documents the collective impact of home visiting program outcomes across all indicators selected through the process outlined in subdivision (a)(2) of this section, as well as data on cost per family served, number of families served, demographic data on families served, and outcomes.

(b)(1) The Department of Health, the Department of Human Services, and the board shall complete and submit the outcomes measurement plan required under this section by October 1, 2014, to the Legislative Council and the Governor.

(2) The Department of Health, the Department of Human Services, and the board shall update the outcomes measurement plan required under this section at least one (1) time each five (5) years, and the plan may be updated at other times if the board, the Department of Health, and the Department of Human Services collaboratively agree to the need for revisions.



(c) Beginning October 1, 2014, a state-funded home visiting program shall follow the outcomes measurement plan and at least annually submit indicator data to the board, the Department of Health, and the Department of Human Services.

(d)(1) The board, the Department of Health, and the Department of Human Services shall produce collaboratively an outcomes report for the Legislative Council and the Governor following the reporting requirements in subdivision (a)(3) of this section.

(2) The report required under subdivision (d)(1) of this section may be structured to facilitate the use of existing reporting requirements including referencing rather than duplicating reports required for submission to the Legislative Council under an existing statute requiring outcome reporting for home visitation programs.

(e) The board, the Department of Health, and the Department of Human Services shall explore the value of including home visiting outcome data in a health-based, education-based, or child welfare-based statewide longitudinal data system for the purpose of monitoring outcomes over time for families that participate in home visiting and other state programs.

(f) The first home visitation outcomes report shall be completed on or before October 1, 2016, and shall be submitted to the Legislative Council and the Governor on or before October 1 of each even-numbered year.

**History.** Acts 2013, No. 528, § 3.

**A.C.R.C. Notes.** Acts 2013, No. 528, § 5, provided: "The State Child Abuse and Neglect Prevention Board, the Department of Health, and the Department of Human Services shall provide recommen-

dations to the General Assembly on or before October 1, 2013, about whether to pursue one (1) or more memoranda of understanding with other state agencies to include home visiting outcome data in state longitudinal data systems."

## **20-78-908. Parental and guardian rights.**

(a) Due to the nature of home visiting programs, this subchapter does not compel a parent's or legal guardian's ability to participate in a home visiting program and does not impede a parent's or guardian's ability to withdraw from a home visiting program at any time.

(b) A decision to withdraw from a home visiting program does not constitute grounds for an investigation of a parent, legal guardian, or member of the family of a minor.

**History.** Acts 2013, No. 528, § 3.

## **CHAPTER 80**

### **COMMUNITY SERVICES**

#### **SUBCHAPTER.**

3. COMMUNITY SERVICE AND COMMUNITY ACTION PROGRAM ACT OF 1985.

4. COMMISSIONER OF STATE LANDS URBAN HOMESTEAD ACT.

SUBCHAPTER 3 — COMMUNITY SERVICE AND COMMUNITY ACTION PROGRAM  
ACT OF 1985

SECTION.  
20-80-308. [Repealed.]

**Effective Dates.** Acts 2003, No. 1473, § 74: July 1, 2003. Emergency clause provided: “It is found and determined by the General Assembly of the State of Arkansas that this act includes technical corrects to Act 923 of 2003 which establishes the classification and compensation levels of state employees covered by the provisions of the Uniform Classification and

Compensation Act; that Act 923 of 2003 will become effective on July 1, 2003; and that to avoid confusion this act must also [sic] effective on July 1, 2003. Therefore, an emergency is declared to exist and this act being necessary for the preservation of the public peace, health, and safety shall become effective on July 1, 2003.”

20-80-308. [Repealed.]

**Publisher’s Notes.** This section, concerning the Community Services Advisory Board, was repealed by Acts 2003, No.

1473, § 47. The section was derived from Acts 1985, No. 345, § 4; A.S.A. 1947, § 83-1110; Acts 1997, No. 250, § 209.

SUBCHAPTER 4 — COMMISSIONER OF STATE LANDS URBAN HOMESTEAD ACT

SECTION.  
20-80-402. Purpose.  
20-80-403. Definitions.

SECTION.  
20-80-405. Applications for donations.

20-80-402. Purpose.

(a) This subchapter shall apply only to urban property and shall be established to prevent waste of valuable real property already offered for public sale and not disposed of which has been certified to the office of the Commissioner of State Lands for nonpayment of ad valorem real property taxes.

(b) The further intent of this section is to provide cities, incorporated towns, legal entities that intend to apply for an award of low-income housing tax credits under Section 42 of the Internal Revenue Code, and community organizations the ability to better serve any eligible person in need of a homestead and to provide the eligible person the opportunity to hold and maintain a private residence, and to contribute to the taxing structure of the applicable taxing units.

**History.** Acts 1993, No. 1009, § 3; 2011, No. 1013, § 1.

**Amendments.** The 2011 amendment inserted “legal entities that intend to ap-

ply for an award of low-income housing tax credits under Section 42 of the Internal Revenue Code” in (b).



**20-80-403. Definitions.**

As used in this subchapter, unless the context otherwise requires:

(1) "Applicant" means any city, incorporated town, legal entity that intends to apply for an award of low-income housing tax credits under Section 42 of the Internal Revenue Code, or community organization applying to the Commissioner of State Lands for donation of tax-forfeited land;

(2)(A) "Community organization" means a recreational, educational, social, or benevolent organization dedicated to improving the mental or physical health and welfare of its members and of the public.

(B) A community organization may be established for community betterment or beautification, environmental protection, establishment of housing, and other purposes beneficial to the community and may be a division of the federal, state, county, or local government or may be a private nonprofit corporation;

(3) "Eligible person" means an individual person or family unit meeting eligibility criteria for the sale, lease, or grant of a homestead. A corporation, partnership, association, or similar organization shall not be an eligible person;

(4) "Homestead" means the home and accompanying or adjoining land of the primary residence of a person; and

(5) "Urban" means land found within the city limits of any city or incorporated town in the state.

**History.** Acts 1993, No. 1009, § 2; 2011, No. 1013, § 2.

**Amendments.** The 2011 amendment inserted "legal entities that intend to ap-

ply for an award of low-income housing tax credits under Section 42 of the Internal Revenue Code" in (1).

**20-80-405. Applications for donations.**

(a)(1) Applications for donation may be made by the following persons or community organizations:

(A) Agents of cities and incorporated towns that also have one (1) of the community organizations listed in subdivisions (a)(1)(B)(i)-(iv) of this section; or

(B) The chair of the board or executive director of one (1) of the following community organizations:

(i) A housing authority;

(ii) A community development agency;

(iii) A community development corporation; or

(iv) A local initiative support corporation.

(2) Other community organizations may apply for donation of the land so long as that organization is a nonprofit corporation that qualifies as an Internal Revenue Service Section 501(c)(3) tax-exempt organization.

(3) A legal entity that intends to apply for an award of federal low-income housing tax credits under Section 42 of the Internal Revenue Code may apply for donation of land under this subchapter

only if the legal entity is a qualified nonprofit organization pursuant to Section 42 of the Internal Revenue Code and accompanying regulations and guidance of the Internal Revenue Service.

(b) Any applicant must have legal authority to accept and convey title to properties for homesteading purposes.

**History.** Acts 1993, No. 1009, §§ 5, 6; 2011, No. 1013, § 3.

**Amendments.** The 2011 amendment added (a)(3).

## CHAPTER 81

### VETERANS' AFFAIRS

SECTION.

20-81-101. Arkansas Veterans' Child Welfare Service.  
20-81-105. Veterans' Home.

SECTION.

20-81-107. Gifts, volunteer services, etc.  
20-81-110. [Repealed.]

**Effective Dates.** Acts 2013, No. 988, § 7: July 1, 2013. Emergency clause provided: "It is found and determined by the General Assembly, that the Constitution of the State of Arkansas prohibits the appropriation of funds for more than a one (1) year period; that the effectiveness of this Act on July 1, 2013 is essential to the operation of the agency for which the appropriations in this Act are provided, and that in the event of an extension of the legislative session, the delay in the effective date of this Act beyond July 1, 2013 could work irreparable harm upon the proper administration and provision of essential governmental programs. Therefore, an emergency is hereby declared to exist and this Act being necessary for the immediate preservation of the public peace, health and safety shall be in full force and effect from and after July 1, 2013."

Acts 2013, No. 38, § 2: July 1, 2013. Emergency clause provided: "Arkansas Veterans' Home Task Force. (a) There is hereby created the 'Arkansas Veterans' Home Task Force'. (b) The task force shall consist of twenty-two (22) members as follows: (1) Three (3) members appointed by the President Pro Tempore of the Senate; (2) Three (3) members appointed by the Speaker of the House of Representatives; (3) The Director of the Department of Veterans' Affairs; (4) The Chair of the Arkansas Veterans' Commission or his or her designee; (5) A representative, chosen

by the organization, of each of the following veteran organizations: (A) The American Legion, Department of Arkansas; (B) The Disabled American Veterans, Department of Arkansas; (C) The Arkansas Council of Chapters of the Military Officers Association of America; (D) The Arkansas Veterans Coalition; and (E) The Department of Arkansas Veterans of Foreign Wars; (6) The Director of the Central Arkansas Veterans Healthcare System or his or her designee; and (7) The following ex officio members of the task force: (A) The Director of the Arkansas Building Authority or his or her designee; (B) The State Procurement Director or his or her designee; (C) The four (4) Arkansas members of the United States House of Representatives or their respective designees; and (D) The two (2) Arkansas members of the United States Senate or their respective designees. (c) If a vacancy occurs for any reason, the vacancy shall be filled in the same manner as the original appointment. (d) The task force shall conduct its meetings in Pulaski County at the State Capitol. (e) The President Pro Tempore of the Senate shall designate one (1) of the Senate members of the task force to organize the first meeting of the task force and serve as chair at the first meeting. (f)(1) By May 1, 2013, the task force shall conduct its first meeting and elect a chair from among its membership. (2) After its first meeting, the task force shall meet upon the call of the chair but shall meet at



least one (1) time per month.(3) The task force shall be dissolved after making its report under subsection (i) of this section. (g)(1) A quorum is required for any action by the task force. (2) Eleven (11) members shall constitute a quorum for the purpose of transacting the business of the task force. (h)(1) The task force shall study issues related to opening a new Arkansas Veterans' Home or homes and develop specific recommendations for review, consideration, and implementation by the General Assembly. (2) Issues to be studied by the task force include without limitation: (A) A needs assessment to evaluate the: (i) Number of current and future Arkansas veterans who have a need for such a facility; and (ii) Extent of services to be offered by any Arkansas Veterans Home or homes. (B) The location or loca-

tions for facilities, to include an evaluation of: (i) Whether existing facilities are available to meet the needs identified in subdivision (h)(2)(A) of this section; and (ii) Possible locations for new facilities; (C) The cost of design and construction of new facilities or of utilizing existing facilities; and (D) The manner and method of funding remodeling or new construction. (i) On or before October 31, 2013, the task force shall submit its report containing its findings and recommendations to the: (1) House Committee on Aging, Children and Youth, Legislative and Military Affairs; (2) Senate Committee on State Agencies and Governmental Affairs; and (3) Legislative Council. (j) The Bureau of Legislative Research shall provide staff for the task force."

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### 20-81-101. Arkansas Veterans' Child Welfare Service.

(a)(1) There is established the Arkansas Veterans' Child Welfare Service.

(2) The service shall be under the direction of a director to be named by the Governor upon written recommendation by the governing body of the American Legion Department of Arkansas.

(3) The Director of the Arkansas Veterans' Child Welfare Service shall serve at the pleasure of the Governor.

(b)(1) The service shall establish a program of furnishing temporary and interim welfare and rehabilitation services and assistance for minor children of honorably discharged Arkansas veterans who are deceased or medically incapacitated.

(2) The service is authorized to enter into contracts and agreements with one (1) or more veterans' organizations in this state, with private individuals or corporations, or with the federal government for the sharing of facilities or services and for the administration of funds in furtherance of veterans' child welfare services.

(c) Funds granted to the service, other than state-appropriated funds, may be deposited in one (1) or more bank accounts in banks in this state and shall be administered in accordance with purposes for which the funds were granted as authorized in this section.

**History.** Acts 1969, No. 189, § 1; A.S.A. 1947, § 11-1409; Acts 1997, No. 100, § 1.

**Publisher's Notes.** This section is being set out to reflect a correction in (a)(3).

## **20-81-102. Department of Veterans' Affairs — Creation — Powers and duties.**

**A.C.R.C. Notes.** Acts 2013, No. 151, § 10, provided: "LIABILITY INSURANCE APPROPRIATION RESTRICTION. In no event shall the Department of Veterans' Affairs expend or transfer any appropriation or funds for the purchase of

malpractice liability insurance for the benefit of a non-governmental entity.

"The provisions of this section shall be in effect only from July 1, 2013 through June 30, 2014."

## **20-81-105. Veterans' Home.**

(a) The Department of Veterans' Affairs is authorized to establish and maintain a Veterans' Home at a location selected by the Director of the Department of Veterans' Affairs, after seeking advice from the Arkansas Veterans' Commission, and the Arkansas Veterans' Home Task Force.

(b) The department is authorized to employ staff to operate the home as it deems appropriate and as authorized by biennial appropriation.

(c)(1) The home shall be operated under the supervision of the department.

(2) The director shall be the administrative head of the home.

(d)(1) The department shall promulgate appropriate guidelines for determining eligibility of veterans for admission to the home and the monetary charges to be made for veterans residing in the home. All guidelines shall conform to the federal requirements to qualify the home as a nursing home for veterans and to render the home eligible to receive federal financial assistance.

(2)(A) Notwithstanding the provisions of § 20-8-101 et seq., the home may be used as a nursing home for veterans without obtaining a certificate of need.

(B) Bed capacity shall not exceed one hundred fifty (150).

(e) In the administration of the home, the director is authorized to do the following:

(1) Establish accounts to record the receipt and disbursement of funds from resident veterans to pay for a portion of their maintenance at the home;

(2) Develop policies for determining charges to be made to resident veterans;

(3) Develop accounts and procedures pertaining to incompetent residents;

(4) Establish procedures and accounts for payment by the home to its residents for work performed at the home;

(5) Establish such other accounts as are necessary to the orderly administration of the home; and

(6) Establish policies necessary for the operation of the home.

(f) At the end of each fiscal year, the director shall certify to the Chief Fiscal Officer of the State the amount of nonrevenues to be retained in the Miscellaneous Agencies Fund Account. All other moneys shall be



transferred to the General Revenue Allotment Reserve Fund according to existing laws.

**History.** Acts 1979, No. 324, §§ 5, 6; 1985, No. 432, § 1; A.S.A. 1947, §§ 11-1414, 11-1415; Acts 1987, No. 157, § 2; 1987, No. 202, § 10; 1989 (1st Ex. Sess.), No. 217, § 10; 1999, No. 634, § 2; 2013, No. 165, § 1.

**A.C.R.C. Notes.** Acts 2013, No. 38, § 1, provided: "Arkansas Veterans' Home Task Force.

"(a) There is hereby created the 'Arkansas Veterans' Home Task Force'.

"(b) The task force shall consist of twenty-two (22) members as follows:

"(1) Three (3) members appointed by the President Pro Tempore of the Senate;

"(2) Three (3) members appointed by the Speaker of the House of Representatives;

"(3) The Director of the Department of Veterans' Affairs;

"(4) The Chair of the Arkansas Veterans' Commission or his or her designee;

"(5) A representative, chosen by the organization, of each of the following veteran organizations:

"(A) The American Legion, Department of Arkansas;

"(B) The Disabled American Veterans, Department of Arkansas;

"(C) The Arkansas Council of Chapters of the Military Officers Association of America;

"(D) The Arkansas Veterans Coalition; and

"(E) The Department of Arkansas Veterans of Foreign Wars;

"(6) The Director of the Central Arkansas Veterans Healthcare System or his or her designee; and

"(7) The following ex officio members of the task force:

"(A) The Director of the Arkansas Building Authority or his or her designee;

"(B) The State Procurement Director or his or her designee;

"(C) The four (4) Arkansas members of the United States House of Representatives or their respective designees; and

"(D) The two (2) Arkansas members of the United States Senate or their respective designees.

"(c) If a vacancy occurs for any reason, the vacancy shall be filled in the same manner as the original appointment.

"(d) The task force shall conduct its meetings in Pulaski County at the State Capitol.

"(e) The President Pro Tempore of the Senate shall designate one (1) of the Senate members of the task force to organize the first meeting of the task force and serve as chair at the first meeting.

"(f)(1) By May 1, 2013, the task force shall conduct its first meeting and elect a chair from among its membership.

"(2) After its first meeting, the task force shall meet upon the call of the chair but shall meet at least one (1) time per month.

"(3) The task force shall be dissolved after making its report under subsection (i) of this section.

"(g)(1) A quorum is required for any action by the task force.

"(2) Eleven (11) members shall constitute a quorum for the purpose of transacting the business of the task force.

"(h)(1) The task force shall study issues related to opening a new Arkansas Veterans' Home or homes and develop specific recommendations for review, consideration, and implementation by the General Assembly.

"(2) Issues to be studied by the task force include without limitation:

"(A) A needs assessment to evaluate the:

"(i) Number of current and future Arkansas veterans who have a need for such a facility; and

"(ii) Extent of services to be offered by any Arkansas Veterans Home or homes.

"(B) The location or locations for facilities, to include an evaluation of:

"(i) Whether existing facilities are available to meet the needs identified in subdivision (h)(2)(A) of this section; and

"(ii) Possible locations for new facilities;

"(C) The cost of design and construction of new facilities or of utilizing existing facilities; and

"(D) The manner and method of funding remodeling or new construction.

"(i) On or before October 31, 2013, the task force shall submit its report containing its findings and recommendations to the:

“(1) House Committee on Aging, Children and Youth, Legislative and Military Affairs;

“(2) Senate Committee on State Agencies and Governmental Affairs; and

“(3) Legislative Council.

“(j) The Bureau of Legislative Research shall provide staff for the task force.”

**Amendments.** The 2013 amendment rewrote (a); deleted “may be” preceding “authorized” in (b); substituted “director” for “Director of the Department of Veterans’ Affairs” in (c)(2); in (d)(1), deleted “which must be met” preceding “to qualify” and “and domiciliary” following

“nursing home” in the second sentence; in (d)(2)(A), substituted “used as” for “converted to,” deleted “and domiciliary” preceding “for veterans,” and deleted “therefor” at the end; rewrote (d)(2)(B); in the introductory language of (e), substituted “administration” for “administering” and deleted “specifically” preceding “authorized”; deleted “of the home” at the end of (e)(3); and in (f), substituted “At the end of each fiscal year, the director shall” for “The director shall, at the end of each fiscal year” in the first sentence, and “according to” for “in accordance with” in the second sentence.

**20-81-107. Gifts, volunteer services, etc.**

(a) The Director of the Department of Veterans’ Affairs is authorized to arrange for and accept through such mutual arrangement as may be made the volunteer services, equipment, gifts, facilities, properties, supplies, and personnel of any state, county, and municipal offices and agencies and of veterans’ fraternal, welfare, civic, and service organizations in the furtherance of the purposes of this act.

(b) The director may accept on behalf of the Department of Veterans’ Affairs from any natural person or legal entity the donation of real property for use as a cemetery for the interment of Arkansas veterans of the United States armed forces and their immediate next of kin as defined by the department.

(c) The director may accept on behalf of the Department of Veterans’ Affairs from any source the donation of gifts, grants, cash, bequeaths, real or personal property, and equipment for the establishment, construction, maintenance, and operations of any state owned and operated Veterans’ Home.

**History.** Acts 1979, No 324, § 9; 1985, No. 431, § 1; A.S.A. 1947, §§ 11-1418, 11-1423; Acts 2013, No. 988, § 4.

**Amendments.** The 2013 amendment added (c).

**20-81-110. [Repealed.]**

**Publisher’s Notes.** This section, concerning official flower, was repealed by Acts 2013, No. 1145, § 6. This section

derived from Acts 1939, No. 189, §§ 1-3; A.S.A. 1947, §§ 11-1708 — 11-1710.

**CHAPTER 82**  
**VICTIMS OF VIOLENT CRIMES**

SUBCHAPTER.  
2. ARKANSAS CHILD ABUSE/RAPE/DOMESTIC VIOLENCE COMMISSION.



**SUBCHAPTER 2 — ARKANSAS CHILD ABUSE/RAPE/DOMESTIC VIOLENCE COMMISSION**

SECTION.

20-82-208. Community Grants for Child Safety Centers Program.

20-82-209. Multidisciplinary teams — Protocols created — Responsibilities.

SECTION.

20-82-210. Subcommittee on Child Safety Centers — Members — Duty to oversee child safety centers.

**20-82-208. Community Grants for Child Safety Centers Program.**

(a) FINDINGS AND PURPOSE.

(1) The General Assembly finds and determines that:

(A) Abused children often have to describe their sexual or physical abuse several times to different professionals at different locations;

(B) Many child abuse investigations are conducted with little collaboration between the agencies involved in the cases;

(C) Each agency's child abuse professionals are housed in different facilities and, as a result, interface during the investigation and management of cases is limited;

(D) Sexual and physical abuse medical examinations are commonly performed in hospital emergency rooms and other sites that are frightening to children, lack the proper equipment, and often are staffed by physicians uncomfortable with these exams; and

(E) Child safety centers provide:

(i) A more child-friendly atmosphere;

(ii) Reduced trauma to the children and their families;

(iii) Improved investigations and management;

(iv) More effective utilization of multiagency information;

(v) Greater protection of children;

(vi) Increased prosecution of perpetrators; and

(vii) Less unnecessary family intervention.

(2) The purpose of this section is to encourage the use of existing child safety centers and the development of new centers providing the benefits under one (1) roof.

(b) ESTABLISHMENT AND AUTHORITY.

(1) There is established the Community Grants for Child Safety Centers Program.

(2) The Arkansas Child Abuse/Rape/Domestic Violence Commission shall advise the Child Abuse/Rape/Domestic Violence Section within the office of the Chancellor of the University of Arkansas for Medical Sciences on the administration and monitoring of this grant program for the operation of existing child safety centers and the development of new centers in the State of Arkansas.

**History.** Acts 2001, No. 1631, §§ 1, 2; 2007, No. 703, § 17; 2009, No. 952, § 18.

**Amendments.** The 2009 amendment inserted "their" in (a)(1)(E)(ii).

**20-82-209. Multidisciplinary teams — Protocols created — Responsibilities.**

(a) As used in this section, “multidisciplinary team” means a local team operating under a statewide model protocol developed by the Arkansas Child Abuse/Rape/Domestic Violence Commission governing the roles, responsibilities, and procedures of the multidisciplinary team.

(b) The commission shall:

(1)(A) Prepare and issue a statewide model protocol for local multidisciplinary teams regarding investigations of child abuse and the provision of safety and services to victims of child abuse.

(B) The statewide model protocol shall describe coordinated investigation or coordinated services, or both, of state and local law enforcement, the Department of Human Services, and medical, mental health, and child safety centers; and

(2) Review and approve a protocol prepared by each local multidisciplinary team.

(c) Each multidisciplinary team shall:

(1) Develop a protocol consistent with the statewide model protocol issued by the commission; and

(2) Submit the protocol to the commission for review and approval.

**History.** Acts 2007, No. 703, § 18; inserted “of child abuse” and “to victims” 2009, No. 952, § 19. in (b)(1)(A).

**Amendments.** The 2009 amendment

**20-82-210. Subcommittee on Child Safety Centers — Members — Duty to oversee child safety centers.**

(a) The Arkansas Child Abuse/Rape/Domestic Violence Commission shall establish a Subcommittee on Child Safety Centers.

(b) The subcommittee shall consist of seven (7) members appointed as follows:

(1) Three (3) members appointed by the commission; and

(2) Four (4) members appointed by the Arkansas Legislative Task Force on Abused and Neglected Children.

(c) The subcommittee shall oversee the operations of the child safety centers with regard to child abuse.

**History.** Acts 2007, No. 703, § 18.

**CHAPTER 86**

**FAMILY SAVINGS INITIATIVE ACT**

SECTION.

20-86-104. Definitions.

20-86-105. Proposals.

20-86-106. Individual development account.

SECTION.

20-86-109. Matching funds.

20-86-111. Reporting requirements.

20-86-112. Implementation.

20-86-113. Reports — Recommendations.



**20-86-104. Definitions.**

As used in this subchapter:

(1)(A) "Administrative costs" includes, but is not limited to, soliciting matching funds, processing fees charged by the fiduciary organization or financial institution, and traditional overhead costs.

(B) Administrative costs shall be limited to no more than ten percent (10%) of the contract;

(2) "Eligible educational institution" means the following:

(A) An institution described in 20 U.S.C. § 1088(a)(1) or § 1141(a), as such sections are in effect on January 1, 2000;

(B) An area vocational education school, as defined in 20 U.S.C. § 2471(4), subparagraph (C) or subparagraph (D), as such section is in effect on January 1, 2000; and

(C) Any other accredited education or training organization;

(3) "Federal poverty level" means the poverty income guidelines published for a calendar year by the United States Department of Health and Human Services;

(4) "Fiduciary organization" means the organization that will serve as an intermediary between an individual account holder and a financial institution holding account funds. A fiduciary organization shall be a not-for-profit organization described in § 501(c)(3) of the Internal Revenue Code of 1986, 26 U.S.C. § 501(c)(3), as in effect on January 1, 2000;

(5) "Financial institution" means an organization authorized to do business under state or federal laws relating to financial institutions and includes, but is not limited to, a bank, trust company, savings bank, building and loan association, savings and loan company or association, or credit union;

(6) "Individual development account" means an account created pursuant to this subchapter exclusively for the purpose of paying the expenses of an eligible individual or family for the purposes set forth in § 20-86-107;

(7) "Net worth" means the aggregate market value of all assets that are owned in whole or in part by any member of the household, less the obligations or debts of any member of the household;

(8) "Operating costs" includes, but is not limited to, costs of training individual development account participants in economic and financial literacy and individual development account uses, marketing participation, counseling participants, and conducting required verification and compliance activities;

(9) "Postsecondary educational expenses" means:

(A) Tuition and fees required for the enrollment or attendance of an individual development account holder or immediate family member thereof who is a student at an eligible educational institution; and

(B) Fees, books, supplies, and equipment required for courses of instruction for an individual development account holder or immedi-

ate family member thereof who is a student at an eligible educational institution;

(10) "Qualified acquisition costs" means:

(A) The costs of acquiring, constructing, or reconstructing a residence to be occupied by an individual development account holder or an immediate family member thereof, including, but not limited to, any usual or reasonable settlement, financing, or other closing costs; and

(B) The costs of acquiring or repairing a motor vehicle to be used by an individual development account holder or an immediate family member thereof, including, but not limited to, any taxes, insurance, or registration costs incurred in acquiring a motor vehicle;

(11) "Qualified business" means any business that does not contravene any law or public policy;

(12) "Qualified business capitalization expenses" means qualified expenditures for the capitalization of a qualified business pursuant to a qualified plan;

(13) "Qualified emergency withdrawals" means a withdrawal by an eligible individual that is a withdrawal of only those funds or a portion of those funds deposited by the individual in the individual development account of the individual and that is permitted by a fiduciary organization on a case-by-case basis in accordance with the rules established by the department;

(14) "Qualified expenditures" means expenditures included in a qualified plan, including, but not limited to, capital, plant, equipment, working capital, and inventory expenses;

(15) "Qualified first-time home buyer" means an individual who has no ownership interest in a principal residence during the three-year period ending on the date of acquisition of the principal residence to which this subchapter applies;

(16) "Qualified plan" means a plan for the operation of a business by an individual development account holder or an immediate family member thereof that:

(A) Is approved by a financial institution or by a nonprofit microenterprise program or loan fund, having demonstrated business expertise;

(B) Includes a description of services or goods to be sold, a marketing plan, and projected financial statements; and

(C) May require the eligible individual to obtain the assistance of an experienced entrepreneurial advisor; and

(17) "Qualified principal residence" means a principal residence within the meaning of § 1034 of the Internal Revenue Code of 1986, 26 U.S.C. § 1034, as in effect on January 1, 2000, of an individual development account holder or an immediate family member thereof, the qualified acquisition costs of which do not exceed the average area purchase price applicable to such residence, determined in accordance with paragraphs (2) and (3) of § 143(e) of the Internal Revenue Code, 26 U.S.C. § 143(e)(2) and (3), as in effect on January 1, 2000.



**History.** Acts 1999, No. 1217, § 4;  
2007, No. 252, § 1.

### **20-86-105. Proposals.**

(a)(1) The Department of Workforce Services shall enter into contracts with one (1) or more fiduciary organizations pursuant to the provisions of this section in such a manner that different regions of the state are served by one (1) or more fiduciary organizations.

(2)(A) An organization based in this state which desires to enter into such a contract shall submit a proposal to the department for the right to be approved as a fiduciary organization.

(B) Proposals shall be made upon forms prescribed by the department and shall contain such information as the department may require.

(b) Organizations' proposals shall be evaluated and contracts awarded by the department on the basis of such items as geographic diversity and an organization's:

(1) Ability to market the project to potential account holders;

(2) Ability to leverage additional matching and operating funds;

(3) Ability to provide safe and secure investments for individual accounts;

(4) Overall administrative capacity, including, but not limited to, the certifications or verifications required to assure compliance with eligibility requirements, authorized uses of the accounts, matching contributions by individuals or businesses, and penalties for unauthorized distributions;

(5) Capacity to provide financial counseling and other related service to potential participants;

(6) Capacity to provide other activities designed to increase the independence of individuals and families through home ownership, small business development, enhanced education and training, saving for retirement, and automobile purchase, or to provide links to such other activities; and

(7) Operating costs.

(c)(1) For each contract entered into pursuant to the provisions of this section, the contract shall begin no later than October 1 of each year.

(2)(A) The fiduciary organization shall use not less than seventy percent (70%) for matching funds and not more than thirty percent (30%) for operating and administrative costs.

(B) Administrative costs shall be limited to ten percent (10%) of the contract.

(d) Responsibilities of a fiduciary organization shall include, but not be limited to, marketing participation, soliciting matching contributions, counseling project participants, conducting basic economic and financial literacy training and individual development account use training for project participants, and conducting required verification and compliance activities.

(e) Neither a fiduciary organization nor an employee of or person associated with a fiduciary organization shall receive anything of value, other than compensation for services, for any act performed in connection with the establishment of an individual development account or in furtherance of the provisions of this subchapter.

**History.** Acts 1999, No. 1217, § 5;  
2007, No. 252, § 2.

### **20-86-106. Individual development account.**

(a)(1) An individual who is a resident of this state may submit an application to open an individual development account to a fiduciary organization approved by the Department of Workforce Services pursuant to the provisions of § 20-86-105.

(2) The fiduciary organization shall approve the application only if:

(A) The individual has gross household income from all sources for the calendar year preceding the year in which the application is made that does not exceed one hundred eighty-five percent (185%) of the federal poverty level; and

(B) The individual's household net worth at the time the individual development account is opened does not exceed ten thousand dollars (\$10,000) disregarding the primary dwelling and one (1) motor vehicle owned by the household.

(b) An individual opening an individual development account shall be required to enter into an individual development account agreement with the fiduciary organization.

(c) The fiduciary organization shall be responsible for coordinating arrangements between the individual and a financial institution to open the individual's individual development account.

(d)(1)(A) Each fiduciary organization shall provide written notification to each of its eligible individual development account holders of the amount of matching funds provided by the fiduciary to which each such individual development account holder is entitled.

(B) Such notification shall be made at such intervals as the fiduciary organization deems appropriate but shall be required to be made at least once each calendar year.

(2) The amount of such matching funds for each individual development account holder shall be three dollars (\$3.00) for each one dollar (\$1.00) contributed to the individual development account by the individual development account holder during the preceding calendar year. The amount of such matching funds shall not exceed two thousand dollars (\$2,000) per individual development account holder or four thousand dollars (\$4,000) per household.

(3) If the amount of matching funds available is insufficient to disburse the maximum amounts specified in this subsection, amounts of disbursements shall be reduced proportionately based upon available funds.

(e) If an individual development account holder has gross household income from all sources for a calendar year which exceeds one hundred



eighty-five percent (85%) of the federal poverty level, the individual development account holder shall not be eligible to receive funds pursuant to the provisions of subsection (d) of this section in the following year.

(f)(1) In the event of an individual development account holder's death, the account may be transferred to the ownership of a contingent beneficiary or beneficiaries. An account holder shall name a contingent beneficiary or beneficiaries at the time that the account is established and may change the beneficiary or beneficiaries at any time.

(2) If the named beneficiary or beneficiaries are deceased or cannot otherwise accept the transfer, the moneys shall be transferred to the fiduciary organization to redistribute as matching funds.

**History.** Acts 1999, No. 1217, § 6;  
2007, No. 252, § 3.

### **20-86-109. Matching funds.**

(a)(1) Any individual, business, organization, or other entity may contribute matching funds to a fiduciary organization.

(2) The funds shall be designated to the fiduciary organization to allocate to participants who meet the requirements in § 20-86-106.

(b)(1) A credit shall be allowed against the income tax liability imposed by the Income Tax Act of 1929, § 26-51-101 et seq., for any Arkansas taxpayer who contributes to a fiduciary organization created pursuant to this subchapter in an amount equal to fifty percent (50%) of the amount of matching funds contributed to a fiduciary organization during the calendar year.

(2) The amount of the credit that may be used by a taxpayer for a taxable year shall not exceed the lesser of twenty-five thousand dollars (\$25,000) or the amount of individual or corporate income tax otherwise due.

(c) Any unused credit may be carried over for a maximum of three (3) years up to a total tax credit allowed in the amount of twenty-five thousand dollars (\$25,000).

(d)(1)(A) To claim the benefits of this section, a taxpayer must notify the fiduciary organization that the taxpayer intends to make a contribution and the amount of the contribution.

(B) The fiduciary organization shall then notify the Department of Workforce Services and request a certification from the Department of Workforce Services certifying the amount of the tax credit to which the taxpayer is entitled.

(C) The fiduciary organization shall deliver the certification to the taxpayer upon receipt of the contribution.

(2) A taxpayer must file the certificate with the taxpayer's income tax return for the first year in which the taxpayer claims a tax credit under this subchapter.

(e) The total amount of tax credits certified under this subchapter shall not exceed one hundred thousand dollars (\$100,000) per calendar year.

- (f) The Department of Finance and Administration shall promulgate any regulations necessary to carry out the provisions of this section.
- (g) The Department of Workforce Services may monitor the use of these funds by fiduciary organizations.

**History.** Acts 1999, No. 1217, § 9; 2007, No. 252, § 4; 2009, No. 1468, §§ 1, 2.  
**Amendments.** The 2009 amendment added the (a)(1) and (a)(2) designations; rewrote (a)(2); and added (g).

**20-86-111. Reporting requirements.**

- Each fiduciary organization shall provide quarterly to the Department of Workforce Services the following information:
- (1) The number of individuals making deposits into an individual development account;
  - (2) The amounts deposited in the individual development account;
  - (3) The amounts not yet allocated to individual development accounts;
  - (4) The amounts withdrawn from the individual development accounts and the purposes for which the amounts were withdrawn;
  - (5) The balances remaining in the individual development accounts;
  - (6) The service configurations such as peer support, structured planning exercises, mentoring, and case management that increased the rate and consistency of participation in the demonstration project and how such configurations varied among different populations or communities; and
  - (7) The number of grievances filed, the resolution of the grievances, and any penalties imposed.

**History.** Acts 1999, No. 1217, § 11; 2007, No. 252, § 5.

**20-86-112. Implementation.**

The Department of Workforce Services shall be responsible for implementation of this subchapter and shall promulgate rules as necessary in accordance with the provisions of this subchapter.

**History.** Acts 1999, No. 1217, § 13; 2007, No. 252, § 5.

**20-86-113. Reports — Recommendations.**

- (a) The Department of Workforce Services shall prepare a written report annually regarding the implementation of the Family Savings Initiative Act and shall make recommendations for improving the program.
- (b) The report shall be transmitted to the General Assembly on or before August 1 of each year.



**History.** Acts 1999, No. 1217, § 12;  
2007, No. 252, § 5.











